

Report of the Independent Assessment of the
Care and Treatment of Mr L
A patient of NHS mental health services

July 2018



The **effective investigations** company

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Acknowledgments

A review of this nature is complex and would not be possible without the support of the families affected or the agencies involved.

Consequence UK Ltd thanks the mother of Natasha, and the parents of Mr L for the information they shared.

Consequence UK Ltd also thanks the members of the domestic homicide review panel for their engagement with the mental health components of the review process.

Independent Team

The two independent reviewers in this case were:

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- Nicholas Chamberlain Kent.

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Executive summary

Purpose of the investigation

In November 2016 Mr L attacked Natasha with a knife. Natasha died because of her injury. The purpose of this investigation was to determine if different action by any of the health agencies involved with Natasha and Mr L could have avoided, or reduced, the opportunity of the tragic incident leading to Natasha's death.

Core terms of reference

The investigation set out to:

- establish what lessons are to be learned from the homicide, with regard to the way in which local professionals and organisations work individually and together to safeguard victims
- establish what lessons are to be learned from the homicide, with regard to the delivery of specialist mental health care to the service user
- identify what those lessons are;
 - within and between agencies,
 - how and within what timescales they will be acted on, and
 - what is expected to change as a result
- apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate
- identify opportunities for preventing domestic violence and homicide, where this is identified as achievable.

Main findings

Natasha had limited contact with primary care and mental health services. The care and treatment she received from the counselling service in 2015 and 2016 was appropriate and there is nothing the independent author, early intervention Team leader, or domestic homicide review panel members can identify that could, or should, have been done differently for her.

Mr L had been in receipt of mental health services, initially in 2012 and then more substantively from 2013. Between this time and September 2015 his care and management seemed to be reasonable; with evidence of fair engagement by him, supported by his parents, with whom the mental health service had a good relationship. From autumn 2015, when his primary care coordinator left the service on secondment elsewhere, the quality of his care contacts was less optimal. This was partly caused by three further changes in care coordinator, his own disengagement, and a lack of robustness in some of the mental health processes, such as risk assessment, risk zoning, and discharge planning. There were also, it seems, some personality issues between Mr L and one of his care coordinators. This is perceived by Mr L's parents as a significant factor in his wholesale disengagement from the mental health service and the support offered to him.

Two weeks prior to Natasha's death, Mr L's mother made a call, to what she believed to be the crisis team, to seek help and an assessment of her son under the Mental Health Act (1983, updated in 2007). However, the number

she had been given in 2015 was for the emergency duty team, hosted by children's services. Therefore this was the number she used. The approved mental health professional on duty, the evening of 18 November 2016, did not consider the call from Mr L's mother to constitute a request, as nearest relative, for an assessment of Mr L under the Mental Health Act. He did, however, recognise that an assessment of him needed to be achieved. This was not achieved on 18 November; unfortunately, a referral was not made to the emergency duty team group referral tray on the Allis system by the emergency duty approved mental health practitioner so cases for follow up could not be picked up by the adult social care team. Similarly, this case was lost to the approved mental health practitioners who would in all likelihood have followed it up the next day.

This resulted in the loss of Mr L from the adult social care system until 23 November, after the incident where he stabbed Natasha.

Conclusion

This is a tragic case, as every needless loss of life is.

The care and management of Mr L was, for the most part, reasonable, but with perpetual scope for improvement in relation to:

- care programme approach
- risk assessment
- zoning (a colour coded approach to prioritising higher risk patients)

From July 2016, there were clear signs that Mr L's mental health was deteriorating. He was on what is termed the 'amber zone' of the risk categorisation used by the early intervention service. Optimal management would have been to place him in the higher risk red zone. This did not happen.

One reason for this was the lack of assertiveness in care coordinator 3 in insisting that Mr L's case was discussed at the zoning meeting. This lack of assertiveness was the result of her experience of being told that only service users already in the red zone could be discussed. This is contrary to reassurance provided by the consultant psychiatrist to the mental health Trust's investigation team that team members were able to raise concerns about risk, even if the threshold for the red zone had not been reached. That Mr L's case was not discussed was a significant contributory factor in continuing with the plan to discharge him from the service. This process was concluded in the first week of November 2016.

On 18 November 2016, Mr L's mother reported a significant deterioration in her son. Her concern was such that she contacted the emergency duty team in her local borough county council. The duty social worker concurred that her concerns were well placed and advised her to contact the ambulance service. On balance, it is agreed that this was an erroneous judgement; the social worker ought to have contacted the duty GP and attended at Mr L's home himself to assess the situation with police support, as it had been reported that Mr L had access to a knife and had recently threatened his girlfriend with

it. The local authority is conducting a separate capability review with the practitioner because of what happened.

It is also agreed that if it were not possible to conduct a visit that evening, or if the urgency for this was reduced because Mr L's mother, at a later point, reported a calming in her son, then an assessment of Mr L should have been highlighted as required within the next few days. This may have included an assessment under the Mental Health Act (1983 updated 2007) if Mr L did not agree to being assessed voluntarily.

The team manager of the early intervention service at the time told the report author that had they been aware of the events of 18 November they would have i) attended at Mr L's home to try and assess him and ii) if he refused to be assessed would have organised an assessment under the Mental Health Act. A warrant authorising entry to Mr L's home would also have been applied for.

Had any of the above occurred, there is a realistic possibility that the subsequent sequence of events would have been different, and Mr L may have become fully, or partially, re-engaged with a mental health team and medication. This means that it is possible that the death of Natasha may have been avoidable. There are no guarantees, but the missed opportunities in the months and weeks close to the time of the incident are such that 'potential avoidability' must be accepted.

Recommendations

The mental health Trust

Due to the commitment demonstrated in the Trust to improving standards in the early intervention service, the author of this report has no additional priority recommendations to make. Changes made by the Trust include: more active frontline management and staff's positive response to this, common standards reinforced around the care programme approach¹ (CPA), CPA plus, risk assessment, and zoning.

The learning points identified in this report do, however, need to be considered, with a response provided to NHS England as to how these principles of practice are to be incorporated into everyday practice.

The mental health Trust and borough county council

Recommendation 1 – the location of the emergency duty team

The one issue arising from this case that cannot be allowed to continue is the lone working situation for adult and children's emergency duty teams. How these teams can be co-located with other out of hours mental health teams must be explored. It simply does not make logical sense for them to be geographically separate. The baseline objective that must be achieved is that there are reliable communications between the emergency duty team, the

¹ The care programme approach is a system of delivering community mental health services to individuals diagnosed with a mental illness. It is a key component of mental health care in England.

crisis team, and the rapid response and assessment team (RAID) when concerns are raised about individuals with a known mental health diagnosis. The co-location of services, particularly out of hours, may be one way of facilitating this. However, it will not be the only solution; the NHS mental health Trust and the local borough county council providing adult social care are required to explore how optimal consistency and reliability can be achieved, and to develop a joint action plan for delivering this.

Recommendation 2 – access to NHS mental health records

The current situation where a social worker's access to NHS mental health records is terminated, either because they have not accessed these in a set number of days, or because they have forgotten to update their password (for which there is no reminder system), needs to be reviewed and remedied.

The objective that needs to be consistently achieved is up-to-date and reliable information for the emergency duty team regarding individuals known to the NHS mental health provider. The IT teams for the NHS provider and the borough county council, alongside practitioners in adult and children's social care who need to 'check' for known history of referred individuals out of hours, need to work out a more reliable and failsafe mechanism for this to be achieved.

Relying on frontline professionals to remember to log in on a time bound basis and change their passwords is not a reliable process with failsafe characteristics.

Other learning opportunities

The learning opportunities listed below represent issues that require an uplift in professional knowledge, insight, and behaviour. Addressing these factors is notoriously difficult. The author of this report asks the involved agencies to bring together staff that work in the areas identified, to involve them in designing an improvement plan that is deliverable, and has some features of sustainability and measurability in terms of 'demonstrating' improvement in the immediate, medium, and longer term.

Learning opportunity 1

Mr L's drinking habits were a perpetual problem. To enable an achievable harm reduction strategy, it is useful if clinicians find out more detailed information about a person's pattern of drinking, including:

- the percentage alcohol beer/larger being consumed
- the can size being consumed.

These factors can make a significant difference and slight alterations such as reducing the percentage alcohol and/or can size can make a positive difference.

Target agencies: NHS, Adult Social Care.

Learning opportunity 2

There are a range of support networks for families and friends of problem drinkers. There is no indication in this case that Mr L's parents, or Natasha, were advised of these. Given the enabling role friends, family, and partners often hold in such cases, not only is it beneficial to the non-drinker to receive support, the support provided to significant others can enable them to change their behaviours around the drinker; this can have a positive impact and result in a reduction in the harmful behaviour. The Trust and the local borough county council needs to set out how it will enhance the education of educates its staff in such matters, and how it will enhance promotion of such networks to families, carers and partners.

Target agencies: NHS, Adult Social Care.

Learning opportunity 3

Where there are concerns about a partner/carer, and they have given verbal reassurances that they are going to keep themselves safe and stay away from a 'risky individual', then suddenly change their minds, prudence requires that the care coordinator needs to try and create a situation where he/she can speak with the partner/carer on their own to understand what has triggered their change of mind.

Target agencies: Although this issue arose in the NHS, it is of equal relevance to all sectors working with individuals who may be abused or where there are professional concerns about this.

Learning opportunity 4

No agency was identified as the communication hub during the management of events on the night of 18 November 2016. As the concern was one of a deteriorating mental state, it seems logical that the emergency duty team needed to act as the communication hub in this case. On a more reflective note, could the emergency duty team have undertaken the initial liaison with the ambulance service about the need to assess the home scenario with Mr L, rather than asking his mother to do this? This may have resulted in a more cohesive response.

Note: developments within the ambulance service mean that it can now refer directly to the crisis team if it is concerned about an individual, as it was in the case of Mr L.

Target agencies: the Borough County Council.

Learning opportunity 5

On 23 November, adult social care had a conversation with Natasha, during which she advised she would not be returning to live with Mr L unless he engaged with mental health services. Neither her mother, nor Mr L's mother, would have had any confidence in this assertion, had they been aware of it, because of their observed behaviour of Natasha in relation to Mr L. Statutory services have no control over the actions and decisions made by individuals, but what adult social care could have done was to inform Natasha about the

website, Wellbeing [R] hosted by the charity MIND. This site has a wealth of information; Natasha needed support in managing and living with a problem drinker as much as living with his mental health disorder. Now it is aware that the information service exists, the borough county council has committed to building on the current knowledge base of support services and multi-agency teams in relation to the resources available to people experiencing domestic violence. The borough county council will also consider establishing lead professionals within the service, and how it can build a stronger awareness of the issues related to domestic abuse; including recognition that power and control issues may prevent a person accepting support when initially offered. The borough county council informed the independent author that it recognises the importance of proactively ensuring that the victim and his/her family have knowledge of sources of information about where support can be accessed for them at a further point in time. This includes building strong links with the local NHS mental health service, independent domestic violence advocacy services, housing, and the prevention team.

Target agencies: although this issue arose in adult social care, it is of equal relevance to all sectors working with individuals who may be abused, or where there are professional concerns about this.

Learning opportunity 6

The ineffective zoning of Mr L, in terms of his increasing risk factors and the lack of oversight of his 'amber' zone status, is a recognised learning point for the involved team and the mental health Trust; at the time Mr L was a service user there was no clear organisational approach to zoning, and no audit of practice. The learning that has emerged from this independent review process, alongside previous recognition in the mental health Trust of the need to develop practice and enhance knowledge in relation to zoning, is already being implemented with the development of a corporate standard, training for all staff using zoning, and audit of practice.

Target Audience: the NHS mental health provider.

Learning opportunity 7

In the early intervention records reviewed, there was a lack of clarity regarding the recording of the efforts and interventions offered, such as:

- family intervention work
- access to Mr L for the supported employment programme
- the undertaking of physical health assessment
- carer-focussed education and support programme.

These are now NHS England Commission for Quality and Innovation targets, which are designed to achieve transparency and an overall improvement in healthcare. The narrative style records used up to 2016, and the design of the mental health review document, meant it was not clear to what extent the above quality indicators were being delivered. This particularly relates to the 2015 – 2016 care period, after care coordinator 1 had taken a secondment elsewhere.

Target Audience: the NHS mental health provider.

1. Introduction to main report

NHS England commissioned Consequence UK Ltd to undertake this independent process, to be delivered in partnership with the already commissioned Domestic Homicide Review, following the death of Natasha on 28 November 2016. Natasha was the girlfriend of Mr L and had been co-habiting with him for a short time prior to her death. Mr L had a diagnosis of paranoid schizophrenia and had been discharged from the Early Intervention Team approximately four weeks prior to his fatal attack on Natasha.

Normally, when an individual unlawfully kills another and they have a mental health diagnosis, and have been in receipt of mental health care and treatment in the time preceding the victim's death, NHS England commissions a dedicated independent analysis of the mental health care.

In this case, the following NHS providers had been engaged with either Mr L, or Natasha, in the six to twelve months preceding Natasha's death:

- the local acute hospitals Trust
- the local mental health NHS Foundation Trust
- the regional ambulance service
- primary care services.

Because all providers were required to attend the domestic homicide review panel meetings, it was neither pragmatic nor productive to require the same agencies to participate in a separate NHS independent process.

The appointed Chair for the domestic homicide review panel and the appointed independent investigator for NHS England had previously worked together on a case that met the criteria for both processes, and had found it was possible to undertake a joint process to deliver meaningful analysis and learning. Consequently, there was no impediment in doing so again.

The agreement was that the domestic homicide review Chair would lead panel meetings attended by representatives, rather than frontline professionals, of all agencies involved. The NHS England appointed investigator was responsible for critiquing the information provided by all agencies and identifying where additional information was required, including from frontline professionals. As a consequence of this process the investigator determined the need for a range of one-to-one and small group interviews with staff from:

- the mental health Trust early intervention team, and the counselling service
- the local borough county council emergency duty team, Adult Social Care
- the regional ambulance Service, specifically the crew who attended to assess Mr L on 18 November 2016.

The only health agency from whom further information was not required was the local acute Trust, who provided an early pregnancy service to Natasha. Because the pregnancy did not continue they had no material ongoing involvement with her.

In addition to the above, it was recommended that a multi-agency frontline professional meeting occur to specifically explore events that occurred on 18 November, which was the last time any agency had contact with Mr L or Natasha; this was two weeks prior to the incident leading to Natasha's death.

This report sets out an assessment of the care and management of Mr L and Natasha from the perspective of the health agencies involved.

It also sets out the improvements identified by each agency, and whether they are fully implemented or remain in-progress.

Outstanding issues are addressed within the recommendation section of this report.

2. Terms of reference and approach taken to this joint domestic homicide NHS investigation

This independent process was conducted with consideration to the statutory domestic homicide process terms of reference and the core terms of reference required by NHS England for independently commissioned level three investigations following mental health homicide.

Core to both are to:

- establish what lessons are to be learned from the homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate
- identify opportunity for preventing domestic violence and homicide where this is identified as achievable.

Specific to the purpose of the NHS independent commission process are to:

- review the appropriateness of 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 their offence, identifying both areas of good practice and 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, and involve the relatives in the investigation as fully as considered appropriate
- review and assess compliance with local policies, national guidance, and relevant statutory obligations
- consider if this incident was either predictable or preventable.

To deliver the needs of both independent processes, without unnecessary duplication of the investigation process, a decision was made that the NHS England provider would be a core member of the domestic homicide review panel. In addition, the NHS England provider determined any additional investigation activities needed to meet the standard of investigation required; namely, to enable a more careful exploration of Mr L's and Natasha's care and management by NHS services, particularly mental health services, than might otherwise be possible within the constraints of a traditional domestic homicide review.

Therefore, in this case:

- a range of one-to-one and small group interviews were conducted with staff within the early intervention team
- an interview with Natasha's counsellor

- access was provided to the interview of the ambulance crew who attended at Mr L's home on 18 November 2016
- an interview with the social worker who was on duty the night of 18 November was conducted
- a multi-agency frontline professionals meeting was hosted, to which all professionals involved on 18 November 2016, and/or their managers, and/or team leaders, were invited. Also invited were the domestic homicide review chair, the domestic homicide review co-chair, and the advocate for Natasha's mother, all of whom attended.

3. Communications with Mr L, his family and the family of Natasha

Communication with Mr L

The report author and the patient safety lead at the mental health trust met with Mr L on 18 April 2018 to discuss the investigation process with him, and to hear about any aspect of his care and management he thought could have been improved.

The most important message arising from the conversation was the importance of continuity of care coordinator. Mr L considered that he had a good relationship with care coordinator 1 and listened to her. He recalled the relationship with care coordinator 2 was 'OK' but not so good with care coordinator 3. Regarding care coordinator 4, Mr L told the report author and patient safety lead at the mental health that he never believed he was a mental health nurse. He believed him to be impersonating as such which is why he would not meet with him.

The conversation held around continuity of carer led to a broader conversation regarding the effective transfer of care, between care coordinators and between teams. The patient safety lead for the mental health trust agreed to take back to the Trust the approach within and across early intervention and community mental health teams to transitioning service users where a change in care coordinator was necessary and a planned approach could be achieved. Similarly, where a change of care team became necessary as in this case.

Mr L acknowledged that he was very unwell and delusional at the time he harmed Natasha.

Communication with Natasha's and Mr L's families

To ensure there were no mixed or missed communications with either Natasha's or Mr L's families, the Chair of the domestic homicide review panel and the investigation lead for NHS England agreed that the domestic homicide review Chair would be the primary contact for both, but that both the Chair and the NHS England lead would endeavour to meet each family representative together.

This was achieved for Mr L's father, but the NHS England lead was unable to attend the meeting between the domestic homicide review Chair, Natasha's mother, and her advocate Julian Hendy (from the Hundredfamilies charity²).

An early decision was made to include the advocate for Natasha's family as much as possible in the review process so that enhanced assurance could be achieved regarding:

² Hundredfamilies provides support to families bereaved following mental health homicide. It was launched by Julian Hendy following the death of his father in 2007 following an attack on him by a person suffering from schizophrenia. <http://www.hundredfamilies.org/>

- openness, honesty, and transparency
- asking and answering questions of interest to Natasha's family.

Consequently, Mr Hendy was the primary point of contact for Natasha's family, and both the NHS England investigation lead and the domestic homicide review Chair communicated with him on an as needed basis.

Communications with Mr L's family required a different approach. Throughout the independent process Mr L remained a patient of the local NHS mental health service, which meant that his parents remained in contact with him and his care team within secure services. In addition to this independent process, they were having to manage the fact that their son was to appear before the Crown Court, accused of murdering his girlfriend.

The NHS England investigation lead and the PALS/Volunteer service manager liaised on several occasions to ensure that Mr L's family were not missing out on support the Trust would otherwise provide because of the independent process. This was done to reduce the risk of communication overload and to ensure that they received the right support in the lead up to Mr L's trial.

At the point the NHS England independent lead was ready to formulate a draft report, the families of Mr L and Natasha were contacted to arrange a date to go through the report. The date agreed with Mr L's parents was 8 November. At this meeting Mr L's parents were able to talk about the impact their son's mental illness and the death of Natasha had had on them. Both parents considered that their son required hospitalisation on 18 November 2016 and cannot understand why this did not happen.

The date agreed with Natasha's mother and her advocate was initially 24 November 2017, but was changed to 15 December to meet family needs. This meeting was also attended by the advocate for Natasha's mother.

3.1 Issues raised by both families

There was unity between Natasha's and Mr L's family about the issue of most importance to them; they both wanted to know why, on 18 November 2016, when Mr L's mother contacted the emergency duty team at the local borough county council Adult Services was it not recognised that she was asking for a Mental Health Act assessment of her son, considering:

- he was behaving strangely
- he was displaying clear signs of delusion and paranoia
- that he had, in the days previously, attacked his girlfriend with a knife
- that he needed detaining in hospital,

Furthermore, why was no mental health assessment of Mr L pursued following the events of 18 November.

In addition to this primary question, both families wanted to know whether, prior to the 18 November, the care and services afforded to both Natasha and Mr L had been of an acceptable standard, and that they had received the right level of service.

4. Areas of practice relevant to this case that the reader of this report needs to be aware of

There are a small number of practice requirements readers of this report need to have an insight in to. These are:

- an Early Intervention Service and what it is for
- the care programme approach
- zoning (the colour coding applied to risk levels)
- counselling service and IAPT
- Adult Social Care and the out of hours emergency duty team service.

4.1 Early intervention services

Early intervention in psychosis services (EIS) can improve clinical outcomes such as admission rates, symptoms, and relapse, for people with a first episode of psychosis between the ages of 14-65. They do this by providing a full range of evidence-based treatment, including pharmacological (low dose atypical antipsychotic medication), psychological (cognitive behavioural therapy - CBT), and family interventions (focussing on psycho-education, problem-solving, communication skills, early warning signs and relapse prevention, social, occupational, and educational interventions), along with physical health checks, and support and education for carers. Treatment from these services should begin within 2 weeks of referral to secondary service from GP's, A&E, liaison psychiatry, inpatient wards, and other agencies with a suspicion of a first episode of psychosis. The aim is to reduce the duration of untreated psychosis. EIS services usually offer support for up to three years, before transfer to the care of the GP or onward to a support and recovery team – also known as a community mental health team (CMHT).

4.2 The Care Programme Approach

The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated, and reviewed for someone with mental health problems or a range of related complex needs. Anyone experiencing mental health problems is entitled to an assessment of their needs with a mental healthcare professional, and to have a formal written care plan that outlines any risks – including what should happen in a crisis. The plan of care should state what the client/patient can expect in the way of support and can be regularly reviewed by the healthcare professional or the team they work with. Usually a care coordinator is appointed who is responsible for the implementation of the care plan, along with the client/patient. A formal review is made at least once a year – in EIS usually every six months – to review the persons circumstances, including whether CPA support is still needed.

4.3 Zoning

Zoning provides a framework for managing risk, targeting resources, and promoting continuity of care. It is a visual system that allows the Multi-Disciplinary Team to quickly identify individual service users across the team's entire caseload who present with increased levels of risk and require additional levels of support; ideally to halt the relapse and prevent admission. The zoning process achieves this through care coordinators talking through

their cases and using risk assessment and formulation to inform and drive the interventions.

There are normally four zones, the red, amber, green and black.

4.3.1 Red zone

The red zone represents service users who are considered to be currently at risk, or in crisis, and whose care requires daily review. Service users who are placed in red zone may present with any number of the following needs (this list is not exhaustive):

- subject to CPA+ (individuals must be placed in red zone if subject to this level of CPA)
- unstable mental state/relapse
- at risk of requiring admission to hospital
- significant risk to self or others
- stopped medication or disengaged with the service
- extensive unmet need
- on leave from an inpatient service
- discharged from hospital and yet to receive 7 day follow up
- active child safeguarding concerns
- active adult safeguarding concerns.

4.3.2 Amber zone

The amber zone represents service users whose mental health is becoming unstable; they are experiencing a decrease in their level of functioning and maintenance of coping strategies. They may also be presenting with an increased risk of harm to self or others. Service users who are placed in amber zone will typically present with higher levels of functioning than individuals who are placed in the red zone, and will engage with the service and their planned interventions but will remain in need of a comprehensive plan of care.

4.3.3 Green zone

The green zone represents service users who are stable, are engaging with the services and their planned interventions, and can utilise effective strategies to remain well.

4.3.4 Black zone

The black zone represents service users who reside somewhere other than their own home e.g. hospital or prison. That is a statutory, institutional type setting that would have procedural safeguards and communication protocols around discharge/release etc.

4.4 The primary care counselling service

The counselling service provided by the local NHS mental health service provides a range of treatment and support options for people struggling to cope with low mood, stress, anxiety, depression, or any of the common mental health problems (that up to 1 in 4 people will experience at some point in their life time). The service operates on an opt-in basis; patients are

provided with a series of 30 minute sessions, normally 8-12. The emphasis is on guided self-work, so the service is geared towards motivated individuals who are committed to dealing with their psychological distress.

4.5 How an emergency duty team works in adult social care

In this case, the local borough county council provides an out of hours service between 17:00 and 08:00 Monday to Friday and anytime (i.e. 24hrs) over weekends and bank holidays. From a social care perspective, the purpose of the emergency duty provision is to provide emergency help with issues such as homelessness, vulnerable adults or children requiring protection, mental health crisis. Approved Mental Health Practitioners and Adult Care emergency duty team workers have a statutory responsibility under Sec 13(1) of the act to consider the case of a patient who is referred and presents within their area; if they have reason to believe that an application for detention in hospital may need to be made. The EDT also work closely with the district nurse service in facilitating urgent respite/emergency short term care placements where there is evidence of carer breakdown and in providing home care packages. Normally, there will be two duty social workers covering a shift; one from adult services, one from children's services. Although children's social workers in emergency duty care can access on call senior management for support, the adult workers cannot. They are expected to manage all queries and concerns identified; attending onsite if required, re-directing the concern to an alternative professional group better placed to provide help, or highlighting the need for action to the daytime team if that is more appropriate. This is commonly referred to as lone-working.

The way the emergency duty team (EDT) refers onto adult social care is as follows:

- a case note entry to a person's profile is made, followed by placing a notification to the Adult Duty EDT group referral tray on ALLIS (the electronic record system in the borough county council)
- this is picked up the next working day by the Adult Care duty administration worker, who signposts to the Duty social worker. In addition, if a case is showing on the ALLIS system that a person is open to an Adult Care social worker, there is option for the EDT social worker to assign the same case note/outcome to the social worker's tray directly. (This was not relevant for this case)
- where a referral to EDT gives reference to adult safeguarding, there is an option for EDT staff to signpost referrals to adult safeguarding via the same tray; the EDT group referral tray on ALLIS
- where a person is showing on the Adult Care system (ALLIS), or Paris system, as open to Community Mental Health Team or the Early Intervention Team, EDT send a notification for follow up, if needed, to the Community Mental Health Team duty mail box – known as EDT.communityteams@r.gov.uk This is accessed daily by Community Mental Health Team administrators and is then signposted to the correct channels on instruction by the EDT worker; for example, referrals can be made to the Approved Mental Health Professional line for known and unknown patients or direct to a Care Co-ordinator if a person is known to the team.

Referrals for people not open to a Community Mental Health Team, and who do not require an Approved Mental Health Professional assessment, but where follow up of some type is required, would be referred to Adult Care and assigned to the duty tray as per the process above.

A Community Mental Health Team does not accept referrals for people who are not already open to their team, unless the person needs to be considered for a referral to the Approved Mental Health Professional service. If an unknown person requires an Approved Mental Health Professional assessment, the Community Mental Health Team administrator would sign post this accordingly.

The EDT can refer to Access and Crisis for lower level mental health referrals; for example, where Mental Health Act Assessment criteria are not quite met and where the EDT Social Worker considers the person would benefit from a mental health assessment, short term piece of work, or intervention. The person being referred needs to agree and consent to this assessment before a referral can be made. The Access and Crisis team work core working hours, 9am – 9pm, 7 days a week and bank holidays; they do not cover 24/7.

5. Chronology

This section of the report sets out a comprehensive overview of the care and management of Mr L during his contact with mental health services

5.1 Overview - Mr L

Mr L was first referred to a consultant psychiatrist by the Crisis Resolution Home Treatment Team (CRHT) and was offered an appointment with the consultant on the 28 March 2008. He did not attend for this. A second appointment was offered for 11 April which he did attend. Following this, Mr L was referred for ongoing care management, as his diagnosis was unclear, with predominant symptoms of anxiety and depression. It was not possible, however, to exclude early signs of schizophrenia. Following consultation with a psychiatrist, Mr L was discharged back to his GP with a recommendation to refer him for psychological therapies. Recommencement with the antidepressant Mirtazapine was also advised.

Mr L was re-referred to CRHT on the 12 September 2012, following attendance at A&E, with a plan to refer to EIT. However, Mr L was missing from home and the early intervention team received a referral from the crisis and home treatment team about him.

The referral was accepted on 20 December 2012.

On 4 January 2013, the early intervention service attended to meet with Mr L while he was an inpatient, and complete a 'Positive and Negative Syndrome Scale' score, known as a PANSS³. However, owing to his level of sedation, this was not completed until 14 January. Mr L subsequently discharged himself from hospital on 15 March 2013. It was at this point that the early intervention team were asked to follow up on him in the community.

His care contacts were dominated by a lack of insight to his mental health issues, with Mr L believing he was suffering from compulsive obsessive disorder. He did not recognise the need for positive engagement with mental health services, refusing therapies such as cognitive behavioural therapy, was inconsistent with medication compliance, and did not recognise, or accept, that his alcohol consumption adversely affected his mental state, particularly his persecutory beliefs. On the rare occasions he did have insight, it was short lived.

In terms of his social situation, Mr L lived independently but was strongly supported by his parents, who tried to facilitate him in life management skills, as well as providing the space in which he and mental health professionals met. His parents had a good relationship with mental health services and received support from Making Space, a third sector support charity⁴. His parents, although committed to supporting their son, consider that he did not

³ The Positive and Negative Syndrome Scale (PANSS) is a medical scale used for measuring symptom severity of patients with schizophrenia

⁴ <http://www.makingspace.co.uk/>

take responsibility for his actions or life choices and frequently experienced frustration as a consequence.

In terms of his previous forensic history, Mr L was charged with assault in 2010, following an alcohol related incident in a night club, and on 30 December 2012. Whilst an inpatient, and detained under Section 2 Mental Health Act (1983 updated 2007), he was involved in an incident where he threw furniture around the ward. Staff intervened, and he was escorted to his room. A further incident occurred when he was violently kicking and smashing glass panels. He then climbed through the hole in the door and left the ward. Although a referral was made to the psychiatric intensive care unit, he was not transferred as he was calm when he returned the following day (as far as can be ascertained from the records).

As far as the author of this report has been able to determine, neither incident would have caused anyone to consider Mr L to be a homicide risk.

Mr L's care delivery from the early intervention team was consistently delivered up to and including August 2015 by care coordinator 1, who had a good relationship with him and his parents. Regular home visits were made and Mr L attended his outpatient appointments, mostly with his mother and care coordinator 1. Depot anti-psychotic medication was attempted in 2014 but, following a small number of doses, Mr L refused to accept it, as he did not believe it assisted him. His paranoid and persecutory thoughts of being followed persisted.

In January 2015 care coordinator 1 was advised by Mr L's parents that he had been drinking heavily over the Christmas period, which in itself was not remarkable. The care coordinator was also informed that Mr L now had a girlfriend – Natasha. Mr L is also reported to be in debt at this time.

Note: A more detailed chronology of the relatively short period Mr L and Natasha knew each other (22 months) follows:

19 January 2015: Mr L's father raises concerns that his son's ability to manage life was compromised. Mr L, however, does not share these concerns. Mr L and his parents reported a loss of memory following a night out in 'the city'. However, when offered a hospital admission to observe him, and check that all was well, he refused.

2 February 2015: At a home visit by care coordinator 1, Mr L was assessed as upbeat, mostly because of his girlfriend. He had been prescribed an anxiolytic by his GP and his girlfriend was trying to help him control his drinking. A decision was made to meet again in eight weeks, unless either Mr L or his parents considered an earlier appointment necessary.

28 April 2015: Mr L was visited at home and revealed that he and Natasha had 'broken up'. He reported feeling OK about this and not being in a low mood. At this meeting care coordinator 1 discussed future options with Mr L, as he had been on their caseload for three years and the time was arriving where he would need to transfer to the community mental health team, which

was the preferred option, or to his GP. Mr L was noted as not wanting to see a psychiatrist but was anxious about a possible discharge and the impact on his benefits. Reassurance about this was noted as being provided and that Mr L was going to discuss the situation with his parents. Soon after, Mr L's mother contacted care coordinator 1, as Mr L was having persecutory thoughts about his sister, believing her to be in contact with the early intervention team (which she was not). His mother reported that, since the breakup with Natasha, her son had less social contacts. She also reported that he continued with his medication for anxiety. Care coordinator 1 advised that an outpatient appointment would be offered and she herself would undertake a home visit on 29 June.

29 June 2015: Mr L met with care coordinator 1. He continued to drink daily and had commenced a volunteering role at an animal sanctuary. He was noted as continuing to refuse anti-psychotic medication. The following day the care coordinator wrote to Mr L's GP advising that he still believes people can control his thoughts and was refusing medication. An appointment was also made with the team's consultant psychiatrist for 23 July 2015.

21 July 2015: Care coordinator 1 made an unscheduled visit to the home of Mr L's parents following a call from his mother. Mr L had attended at their home demanding his banking cards and had behaved threateningly towards them, notably his father. His mother reported calling the police, as she thought her son might do something silly. Consequently, Mr L was arrested and taken into custody for several hours. He was not charged with any offence. Because of this episode, Mr L presented as more willing to both engage with mental health services, and to reconsider medication. He also agreed to attend his planned outpatient appointment.

23 July 2015: At his outpatient appointment Mr L reported a three-week history of auditory and visual hallucinations. He reported preoccupying thoughts but no thoughts of harm to himself or others. Mr L agreed to recommence anti-psychotic depot medication at this appointment. His care coordinator visited him, at home later the same day, to administer this, with the second dose to be administered at the clinic on 3 August.

17 August 2015: A joint visit occurred between Mr L's outgoing and incoming care coordinator. Mr L was noted to be animated and expressing delusional beliefs about being watched. Although he had accepted his first depot injection of anti-psychotic medication on 23 July, he voiced his refusal to accept further anti-psychotic medication, describing a dystonic⁵ reaction to it. He is also reported as refusing to attend his outpatient appointment on 17 September with his psychiatrist.

It was clear to both professionals present that Mr L was anxious about the change in care coordinator, but he did agree to an appointment with his new care coordinator, including to have a physical health check, on 8 September.

⁵ **Dystonia** is a neurological movement disorder syndrome in which sustained or repetitive muscle contractions result in twisting and repetitive movements or abnormal fixed postures.^[1] The movements may resemble a tremor. Dystonia is often intensified or exacerbated by physical activity, and symptoms may progress into adjacent muscles.

8 September 2015: The meeting between Mr L and his new care coordinator took place, and at this he agreed to meet his psychiatrist. He remained adamant that he did not have psychosis.

17 September 2015: Mr L attended his psychiatric outpatient appointment. Key points captured in the letter to Mr L's GP were:

- Mr L did not agree with his diagnosis of schizophrenia
- he continued to believe he was captured and tortured by a gang three years previously
- he continued to believe there are different gangs of people who come and meet him, pick him up, and drop him off at various places
- he expressed a desire to have a wife and family in the future
- when drunk, his mother reported that Mr L was aggressive to the extent that, in recent times, she had had to call the police
- Mr L accepted that he drank too much.

Mr L denied any risk to others and that he was never aggressive towards them. When challenged about this, he acknowledged that when he was under the influence of alcohol he had pushed his father, only because his father was pushing him; it was self-defence. Mr L was noted to say that he "consciously never tried to hurt anyone", and that he "would only do so as self-defence". The psychiatrist wrote "there is a risk in this domain which is unpredictable with his alcohol".

The plan was to:

- start quetiapine (an anti-psychotic medication) XL 100mg, increasing by 100mg per five days until 500mg is reached
- attend for further review in two months
- continue with care coordinator review in the community.

On 17 November 2015 Mr L was reviewed by an advanced practitioner for the early intervention team. The letter sent to Mr L's GP after this identified that:

- Mr L appeared to be harbouring persecutory delusional ideas
- Mr L denied any ideas of harm to himself or others
- the assessor considered that Mr L might be experiencing auditory and visual hallucinations
- Mr L appeared to completely lack insight.

The management plan was to recommence quetiapine XL medication; a script for 100mg for five days, increasing to 200mg for five days was issued by the psychiatrist. Thereafter the GP was advised to increase to 300mg for five days, then 400mg and finally 500mg, with maintenance to be at 500mg.

At this meeting, it was established that Mr L regularly consumed four to five cans of cider each day.

The plan was for Mr L to receive another follow up visit with his care coordinator at the end of November. This did not take place.

19 January 2016: Care coordinator 2 visited Mr L at home, where she discovered he had been binge drinking. He was, however, reporting that he wanted to address his alcohol issues as he recognised the negative effect it had. However, he refused to attend counselling to help him with this. Care coordinator 2 recorded in her record that she provided his parents with information about a self-referral group he could approach if he wished.

At this meeting, issues relating to the quality of Mr L's sleep were discussed. Care coordinator 2 recorded that she discussed 'sleep hygiene' with Mr L, which is practices and habits that are necessary for a good sleep quality at night and full daytime alertness, and includes:

- having a regular time for going to bed
- not watching TV or being at a computer immediately before sleep time
- having a soothing warm non-alcoholic drink
- avoiding coffee and nicotine close to bed time
- avoiding heavy, rich, or fatty foods.

Care coordinator 2 also noted that Mr L remained troubled by traumatic thoughts, even though he was taking his anti-psychotic medication as far as she could ascertain. She recalled to the independent early intervention team leader, and author of this report, that initially, "he started to say that he wanted to take his medication and he started on Quetiapine which was really, which we thought would be really beneficial. So, we were trying to support him with that. We were trying to encourage him. It took a bit of work really for him to be compliant with medication and I wasn't ever sure if he was 100% compliant with that medication but he would say 'I am taking it'. He would also use the Quanax (for anxiety) if he was feeling anxious".

Note: a challenge for staff was the location of most meetings conducted with Mr L. This was at his parent's home, which removed the opportunity for staff to review the medication packets Mr L had. However, his mother was a reliable source of information to his care coordinator, and would indicate if she thought he was not taking it. Non-compliance was a recognised and persistent problem for Mr L.

With regards to his paranoid thoughts these included:

- being kidnapped
- that the mafia were after him
- stabbing someone in the eye
- murdering someone.

The notes say, "He reports he is taking the quetiapine but he is still experiencing the kidnappings and traumatic thoughts, he reports the Mafia are after him and the Mullins family. Mr L said they are sodomizing him and someone made him stab them in the eye, he said this resulted in him murdering someone. Plan [outpatient appointment] to be made this week." There is no evidence of this being explored further to establish if Mr L had any intention of acting on these thoughts or if he could have murdered someone.

Because of these ongoing experiences, care coordinator 2 arranged a further psychiatric outpatient appointment for Mr L the same week.

28 January 2016: Ten days after the home visit by care coordinator 2, Mr L attended for follow up with the team's consultant psychiatrist. At this appointment, Mr L reported he was taking his medication and that he had stopped drinking alcohol. Instead, he reported playing golf and visiting his parents regularly. He also reported a decrease in his paranoia.

At this meeting, the consultant again discussed next steps with Mr L. Normally, one is only on the early intervention team caseload for three years. The information provided by care coordinator 1 in April was reiterated, and at this meeting Mr L apparently indicated he was content to be referred to the community mental health team.

28 January 2016 – 15 March 2016: There are no recorded contacts with Mr L by the early intervention service. The reasons for this length of no contact are unclear.

16 March 2016: Care coordinator 2 made a home visit at Mr L's parents' house, which was the usual meeting place between Mr L and the professionals. At this meeting, she informed Mr L and his mother that she was leaving the early intervention service and another care coordinator would be assigned to him, care coordinator 3.

At this visit Mr L reported that he remained alcohol free as he did not want to be aggressive because of it. Mr L also alleged that the police had arrested and tortured him, suggesting he was not delusion free. Mr L's father was finding his son's behaviour difficult to live with at this time.

22 March 2016: A follow up call was made to Mr L's father by Mr L's new care coordinator, care coordinator 3. However, Mr L answered the phone and cut the caller off. The purpose of the call is not clear.

14 April 2016: Care coordinator 3 sent a text message to Mr L. Verbal telephone contact was subsequently achieved; care coordinator 3 identified delusional content in this. The team manager became involved and asked Mr L if he would attend the John Elliot Unit. Initially the records note that he said yes, then retracted, reporting that he would go and see his girlfriend and await the planned visit for 19 April. (It is unclear when Mr L and Natasha re-established their relationship).

19 April 2016: Care coordinator 3 attended at the home of Mr L's parents. During this visit, it was noted that he had been drinking heavily. Care coordinator 3 recorded that she explained that this, along with the prescribed anti-psychotic medication, would render Mr L vulnerable to further relapse.

The clinical record also set out that Mr L's mother informed the care coordinator that he had started a relationship with Natasha. Mr L himself reported he was taking mixed doses of medication. Care coordinator 3 recorded that she warned him against this as it would not be conducive to stabilising his mood. She also offered him a medication review which he refused.

13 May 2016: A scheduled appointment with Mr L was cancelled owing to staff training commitments. This was re-arranged for 2 June 2016.

2 June 2016: Care coordinator 3 attended at the home of Mr L's parents, but there was no-one at the residence. The care coordinator called Mr L's mother who had forgotten about the appointment that day. It was rearranged for 10 June.

10 June 2016: Care coordinator 3 again attended at Mr L's parents' home. Mr L was noted to be jovial and calm. He was 'back together' with Natasha and they were getting on well. Mr L reported that he had reduced his medication level, which concerned care coordinator 3. Care coordinator 3 also double checked with Mr L and his mother that he would be attending his next outpatient appointment (20 June). The records show that the intent was to discuss Mr L's transfer to the community mental health team at this meeting.

A further home visit from care coordinator 3 was agreed for 13 July 2016.

20 June 2016: Mr L did not attend his outpatient appointment. This was followed up by telephone and it is documented that Mr L reported having felt unwell.

13 July 2016: Care coordinator 3 attended, as planned, to meet with Mr L at his parents. He was not there. His mother reported that she and her husband had a bad night with Mr L and that he had kicked the door in. Consequently, care coordinator 3 and Mr L's mother went to Mr L's house. On arrival Mr L refused to answer door but Natasha agreed to open the back door after a while. On entering the home, the following was observed:

- the kitchen was strewn with beer cans,
- there was rubbish and vomit on the floor.

Mr L, they were informed, was in bed with a hangover and refused to come down, even when requested by his mother. Care coordinator 3 went upstairs to speak with him.

During the visit, Mr L's mother informed care coordinator 3 that Natasha had cerebral palsy and was 5 weeks pregnant. Mr L's mother was noted to consider she thought the news had hit her son hard. It was also noted that she considered he needed to face up to his responsibilities.

Mr L's mother also advised care coordinator 3 that she and Natasha's mother would be meeting, and they would both be providing support to the couple. At this meeting Mr L's mother reported that her son had threatened to kill his neighbours.

Care coordinator 3 said she would make a safeguarding children referral and recorded that she advised Natasha not to be near Mr L when he was intoxicated.

Natasha is reported as informing care coordinator 3 that she would be getting her own accommodation and wouldn't be living with him.

Care coordinator 3 arranged to contact Mr L's mother the following day.
14 July 2016: Care coordinator 3 contacted Mr L's mother and provided contact details of Drug & Alcohol service. Care coordinator 3 decided not to make a safeguarding referral, as Mr L did not appear aggressive towards Natasha. (This aspect of safeguarding practice is now included in the Trust's safeguarding children training).

18 July 2016: A further home visit occurred but there was no-one at home, so it had to be re-arranged. During the conversation between Mr L's mother and care coordinator 3, it was reported that Mr L had improved and that he and Natasha were planning to move in together. Mr L's mother reported that she would support them to find accommodation, and that her son would not be allowed around the child if he was drinking.

26 July 2016: Care coordinator 3 attended at Mr L's home for a planned visit. However, he texted her and asked her to leave without opening the door. He did come to the window, but it seems that no conversation passed between them.

28 July 2016: Two days later the consultant psychiatrist for the early intervention team noted that Mr L had disengaged from the team, that his girlfriend was pregnant, he was due to be evicted from his accommodation, and would require follow up by the community mental health team.

11 August 2016: Mr L was due to attend an outpatient appointment but did not. Care coordinator 3 contacted the community mental health team by phone regarding his care programme approach transfer

23 August 2016: Plans for Mr L's discharge from the early intervention team continue, a discharge crisis plan was formulated, and the only activity required is a discharge care programme approach meeting with Mr L, care coordinator 3, and the community mental health team. The impediment to this, at the time, was Mr L's unwillingness to engage.

13 September 2016: An outpatient appointment for Mr L was cancelled by the Trust, no reason for this is recorded in the notes.

29 September 2016: Mr L did not attend his rearranged outpatient appointment. The mental health review documents were completed in his absence by care coordinator 3, she noted that Mr L did not require review before his transfer. The community mental health team consultant psychiatrist was noted as being agreeable to inviting Mr L to a further care programme approach meeting, but it was also agreed that if he did not attend then he would be discharged from the early intervention team back to his GP.

Salient points recorded in the mental health review document by care coordinator 3 were:

- Mr L was normally seen by the care coordinator at his mother's home
- 13 July 2016, Mr L had found out that his girlfriend was pregnant, was questioning whether he was the father, appeared to be deteriorating in

terms of reduced engagement, increase in alcohol intake, his mother also reported that he had threatened to “kill the neighbours”

- Natasha, Mr L's girlfriend, was advised by care coordinator 3 that she ought not to be around him when he was intoxicated with alcohol and aggressive.

Nothing of note is included after July 2016.

The risk assessment completed in July identified that:

- Mr L would not talk about his thoughts and appeared low in mood
- Mr L remained unwilling to accept psychiatric help
- alcohol, was problematic, especially when Mr L was binge drinking
- Mr L had a previous arrest for assault.

The risk assessment does not include reference to Mr L's contemporary behaviour of:

- kicking in his, or his parents', door panel
- the obvious signs of neglect and excessive drinking noted in July
- the reported threat to “kill the neighbours”
- that he is living with a young woman who has vulnerabilities, and who, in July, was reportedly pregnant.

There is no risk management plan in this mental health review document.

29 September 2016: Mr L did not attend his care programme approach appointment; a further date was sent to him. This was for 25 October, but was subsequently cancelled by the outpatient department, as the locum psychiatrist scheduled to be at that clinic unexpectedly left the service the previous week. The replacement locum could not commence duties until a week after Mr L's scheduled appointment. This appointment was to be attended by Mr L's new care coordinator, care coordinator 4.

27 October 2016: Discussion was held between care co-ordinator 4, the team manager and the team consultant, with regards to carrying out a face to face visit with Mr L prior to discharge, as care co-ordinator 4 felt uncomfortable discharging without meeting patient. By this time the community mental health team had made decision to discharge Mr L back to his GP as he had not attended two planned appointments. Mr L was also refusing to meet with care co-ordinator 4, or to engage in the transfer to CMHT.

8 November 2016: Care coordinator 4 attended at Mr L's home to assess him. However, Mr L did not want to interact with him and requested no further visits. He only wanted contact with his GP. As far as care coordinator 4 could determine on this date, Mr L appeared stable and his communications were clear. The plan therefore was to discharge him to his GP, with an offer to the GP of further mental health engagement if required later.

Care coordinator 4 informed Mr L's GP, the following day, that Mr L had been discharged back to his care. The letter informed the GP that:

- Mr L had disengaged from services

- was unwilling to engage with the community mental health team
- Mr L was insistent that he no longer wants, or requires, any home visits from healthcare professionals and requested discharge back to his GP

A copy of the most recent mental health review document, completed by care coordinator 3 was also included, along with a basic crisis plan (basic because its content relied on what was already known about Mr L, because he would not allow a contemporary assessment).

The discharge letter, recommended the GP refer Mr L to the community mental health team if further mental health input was required.

18 November 2016 at 16:48: Mr L's mother contacted the out of hours customer service line within adult social care. Customer services made a referral to the emergency duty team because of this.

The referral stated that Mr L was a "paranoid Schizophrenic and that he reported that he had ripped up the carpet in the bathroom, stating there was a dead body underneath the floor boards". His mother reported that he had torn out smoke alarms believing cameras were inside them. She also advised that her son was not taking his medication and had attacked his girlfriend, Natasha, who had subsequently turned up at her address. Natasha was reported as extremely upset and frightened. Mr L's mother said to the call handler that her son needed "sectioning" as soon as possible and to start taking his medication. She also requested a call back from the emergency duty team social worker as soon as possible.

18 November 2016 at 17:10: the emergency duty team social worker, an approved mental health practitioner, called Mr L's mother, who is reported as advising that her son had calmed down and was now more settled. However, the social worker recorded that she continued to consider her son required treatment in hospital. The social worker advised Mr L's mother to call an ambulance, or to take him to hospital.

18 November 2016 at 17:36: Mr L's mother made a 999 call. As a consequence of the information passed during the call, and the subsequent coding of the call, and because the ambulance service was notably busy that night, the case was passed to the urgent care desk team. A paramedic from this team contacted Mr L himself at 21.04. Based on the information exchanged a safeguarding adults concern was raised. The team considered that Natasha was vulnerable and at immediate risk of harm.

18 November at 17:44: The ambulance service contacted the police to ask for assistance and attendance at Mr L's address. The call log stated, "Assistance required [Mr L] 31 years, at the address, male is paranoid schizophrenic. His parents have called ambulance to tell them that he is having an adverse mental health episode".

In addition, the police captured the following information:

- Mr L's parents advised the ambulance service to send "strong men" as they feared their son might "kick-off"
- Mr L reportedly had recently attacked his girlfriend and ripped up carpets as he thought there was a body hidden underneath them
- Mr L was known to be violent
- Mr L was believed to be off his medication
- Mr L's parents were not on the scene. It was not known who was at the scene with Mr L
- the ambulance would attend at the rendezvous point and await police attendance.

Two minutes after the call was received by the police it was passed to radio dispatchers for attention. Three minutes later the police record notes that the police will await confirmation that the ambulance is at the rendezvous point before attending.

The requirement for ambulance response was graded 'green' by the ambulance service as it was not a life and death situation. This required a twenty-minute response time.

18 November 2016 at 18:23: Almost 40 minutes after the ambulance service had sought support from the police, it had not been able to allocate a vehicle to attend at Mr L's home. At this time, the ambulance service had 105 jobs requiring allocation. These would be allocated in order of priority. It was anticipated that there would be further delay of 45 minutes.

The police confirmed their support for the ambulance service, but they would attend on confirmation of an ambulance being at the rendezvous point, but not before. The police perspective at this time, was the issue was medical. At this time, it was.

18 November 2016 at 19:20: Two hours and 10 minutes after call one, the social worker made his second call to Mr L's mother. His record says that she reported that she was now at her son's house, that she had contacted the ambulance service, and was waiting for it to arrive. The social worker's record also noted that Mr L's mother reported him to be remaining calm, but that he was not aware that an ambulance was going to attend.

18 November 2016 at 19:57: The police noted that the ambulance response was to be delayed by a further 30 minutes. By 20:30 this was noted as 'delayed for 1 hour for night patrol/update form ambulance'.

18 November 2016 at 21:24: The police received further communication from the ambulance service. Their records say: "Disturbance ongoing, [Mr L] suffers from schizophrenia and paranoia. The male is suffering from mental health problems and has previously been violent towards his partner, threatening her with a knife".

This is swiftly followed by the following record made between 21:25 and 21:26 "Female is very distressed over the line, Log 1647 aware. Male called

ambulance from 01*** 416***. Male appears to be calm over the line, female still heard screaming in the background. No further details. Caller [ambulance service] cleared”.

This information escalated the need for an immediate police response because of a possible safety threat to the female (believed to be Natasha). This safety need superseded the ongoing requirement for clinical assessment of Mr L. The police, therefore, went to the address without the ambulance service who were still not in a position to respond owing to higher priority case requirements.

The police records revealed no warnings regarding Mr L, however, they did inform about a previous detention under the Mental Health Act (1983 updated in 2007), which occurred in 2012.

18 November at 21:30: Within five minutes of it being identified that there may be a safety issue for Natasha, the police had arrived at Mr L’s home. The police control room contacted the ambulance service, to determine if an ambulance had been dispatched. They were advised that it had not.

The ambulance service is recorded as advising: “that male stated he is not happy with ambulance involvement, his partner was distressed and he has assaulted dad in the last week.”

By 21:34 two additional officers arrived at Mr L’s home.

At 21:58 the officers at Mr L’s home advised the control room that they were “standing down” because the situation was calm, and there was “nothing apparent for police at this time”.

One minute later the police updated the ambulance service, the record of which said: “Ambulance advised as above also advised to recall should they require assistance at the scene. FWIN⁶ Closed”.

18 November 2016 at 22:00: The ambulance service contacted the out of hours customer service line for adult social care, to discuss the incident number – 16482252 – reported earlier. The incident report stated that Natasha’s boyfriend Mr L was a paranoid schizophrenic and had not been taking his medication. Also, that he had allegedly assaulted Natasha and was believed to have had a knife at some point. The Ambulance Control received the call at 17.36, they called the police at 17.46, police log 1647. A second log number was noted at 21.27 (2182), when the police were re-contacted to inform them of the immediate risk concern to Natasha.

Thirty minutes later, the duty social worker made his third call to Mr L’s mother. It is recorded that she reported Police had since attended the property, but Mr L refused to allow them access into the property. The police decided to leave him at the address as he was calm. They took her back home and Natasha back to her parents’ address. Mr L’s mother said she was

⁶ FWIN means force wide incident number

concerned that her son seemed too calm, and she suspected he “might do something silly”. She reported that he had turned his phone off and was refusing to talk to anybody. The social worker recorded that he advised Mr L’s Mother to contact the service again if there were further concerns during the evening.

Then, at 22:50, the social worker recalled contacting the ambulance service to follow up their call at 22:00 hrs. He noted he spoke to a person called J. J reported to him that they had received the call about Natasha and that Mr L had allegedly assaulted her. J is noted as stating that the call was still in a queue, waiting for an ambulance to be sent to the property. The social worker informed J that police had attended, and Mr L had refused to allow police access to the property, hence the police decided to leave him there. He also advised J that the police had taken Natasha back to her mother’s house. The regional ambulance service has no recording of contact from the social care professional.

The social care timeline made clear there were no further communications with the service that night about Mr L, or Natasha.

18 November 2016 at 22:58: The police received a call from the ambulance service seeking assistance for their attendance at Mr L’s home. The police record states: “Ambulance have received a call from Social Services, states ambulance should not attend this address as the male suffers from paranoid schizophrenia and armed with a knife. Ambulance got this call at 22.51 and need police to re-attend.” Call taker is aware of the existence and finalisation of previous FWIN 2182. Call is assessed for a prompt response and switched to the radio despatchers at 22.58 hrs”.

One minute later there is another note which says: “Have advised ambulance of the notes on FWIN 2182, they have been advised of officer’s updates [on] arrival. Ambulance is not attending without police assistance. Asked when Social Services have obtained the information regarding their updates. Ambulance could not tell me”.

The plan was as previously, for the police to be dispatched once the ambulance response vehicle was at the rendezvous point.

At 23:09 the police are notified that an ambulance has been allocated

At 23:18 The police were notified of the rendezvous point

19 November 2016 at 00:03: The attending police officers contact control room and advise that one is on scene and one is with the ambulance.

No patient contact record was completed by the ambulance crew. A statement obtained by one of the crew members, an emergency medical technician grade 1 (EMT 1), in 2017, revealed that she did not “remember anything being out of the ordinary or unusual about him, if there was I would have certainly taken further action”, and “due to the short time on scene I can only presume

that he didn't want an ambulance, if anything untoward was present I wouldn't have walked away".

19 November 2016 at 10:00: The police public protection unit received a report which says: "The circumstances of this incident are as follows: the mother of [Mr L] has been on holiday for two weeks and returned today. Mr L and Natasha live at the same address, Natasha had contacted Mr L's mother stating his mental health had deteriorated whilst she has been away; he has not been taking his medication in two months. This has made him paranoid and has made him think she is cheating on him. A few months ago, Natasha faked a pregnancy and miscarriage and this appears to be the route of the problem. This deeply hurt him and makes him question his relationship.

Mr L's mother had contacted the ambulance from her home address at 6pm regarding concerns about her son; she had attended their address to speak to Natasha and Mr L. Natasha and Mr L have had issues throughout their relationship, the most recent being the fake pregnancy and miscarriage. The pair appear to be together as they fear they could not get anyone else due to Mr L's mental health problems and Natasha has cerebral palsy. The ambulance contacted police stating that Mr L had been having a schizophrenic episode.

Myself and PC3 attended the address, Mr L came to the door however would not let us enter. We had no power of entry as there were no offences disclosed. All parties present were at the door and appeared safe and well. Natasha stated over the past few weeks Mr L's behaviour had become nastier towards her due to his deteriorating mental health.

In our opinion Natasha appeared vulnerable and wouldn't be capable defending herself if he became violent. For this reason, she was returned to her mother's address. Mr L appeared calm & compliant and made no threats to harm himself or others. His appearance was smart and he was responding to our questions without issue.

Mr L stated his mother was over protective of him since he has been sectioned and he is upset he cannot take over his own finances as a man his age should be able to do so and he would like some independence. The only issue he seemed to have was with his girlfriend and their relationship.

The rapid assessment team were spoken to and stated that if he was happy to attend voluntarily at A & E they would speak with him however stressed no urgency for him to attend. We spoke with mum regarding medical history and how he has been coping on his own she stated up until recently she thought everything was fine.

She stated there was no history of self-harm or suicide. Mr L had not expressed any thoughts of suicide or self-harm. Mr L told us to not enter his house as there were no issues; all parties seen and spoken to.

[We] stressed that he needed to take his medication. Due to the above we took Natasha and mother back home. [Mr L's] Mother was happy to leave

address and stated she would liaise with crisis team. Mr L was left at the address. A short time later we returned with the ambulance. He answered the door his mannerisms were the same he stated he was fine and did not need to speak to them or require an ambulance. No powers as no offences reported or apparent. Medium risk, both require support from adult social services and mental health team. No consent given to share [information].”

21 November 2016: Adult Social Care picked up the safeguarding concern via the secure ALLIS system, that had been shared with EDT on 18 November 2016. The concern stated that Natasha’s boyfriend, Mr L had a diagnosis of paranoid schizophrenia and had not been taking his medication. The concern also stated that Mr L had allegedly assaulted Natasha, who was vulnerable and has cerebral palsy. The concern identified that the paramedic was told that at some point Mr L had a knife. The safeguarding concerned identified that these details were passed by Mr L’s Mother to the paramedic as Natasha was crying in the background. The concern further stated that police had also been called.

The following day, adult social care reviewed the case and a decision was made to follow up Natasha. Firstly, they needed to obtain accurate contact details for her, which was planned for the following day.

23 November 2016: A duty social worker (social worker 2) phoned the GP surgery for Natasha. This request was followed up in writing, as there was a note on Natasha’s record saying her details were not to be divulged without Natasha herself being present. Up-to-date contact details were provided at 11:40.

Four minutes later, social worker 2 phoned Natasha and had a conversation with her.

The record made of this call demonstrates that social worker 2, “explained purpose of call, asked how things were with her boyfriend and whether she felt she needed any support. She [Natasha] explained that she is ok, but Mr L needed help, because he’s a paranoid schizophrenic, not taking medication and he can be verbally abusive. [Social worker 2] asked what the paramedics and police had done, and Natasha stated that they hadn’t taken it any further. Natasha stated that the paramedics didn’t feel that he needed “sectioning⁷”. [She] explained to [social worker 2] that she doesn’t feel that she is at risk and is currently staying at her mothers’ until Mr L receives support as he won’t take his medication. [Social worker 2] asked whether she felt that she needed any help and Natasha stated that she was fine. [Social worker 2] asked whether Natasha was with her mother at the moment. Natasha stated she was then passed the phone to her mother, who confirmed that Natasha was staying with her until Mr L receives support. Natasha’s mother explained that she has discussed it with Natasha but she doesn’t feel that she needs any support. [her] mother explained that Mr L can be verbally abusive more than anything. [Social worker 2] asked Natasha’s Mother whether she felt Natasha

⁷ The regional ambulance service consider this to be hearsay, as there is no evidence that the attending crew fully assessed Mr L in relation to his mental health needs.

was at risk and [her] mother explained that she doesn't feel she is - it's more around verbal abuse than anything. Natasha's mother stated she feels Mr L needs support to ensure that he takes his medication but he is refusing for this to be put into place and has refused for a Community Psychiatric Nurse to be involved.

[Social worker 2] recorded that she explained to [Natasha and her Mother] the support that could be put into place with Victim Support to help her cope with the verbal aggression and if she felt she needs the support, she was to contact adult care”.

On the same day, at 12:19, social worker 2 discussed Natasha with the advanced practitioner/duty manager and case closure was agreed.

On the same day, at 14:14, a referral was received by adult social care from the public protection unit. This referral was uploaded onto a system called ALLIS to both Mr L's and Natasha's record; PPIU ref PPI/H002789506. The information on the record states:

“Mr L's mother was concerned that [her son's] mental health has deteriorated and that he had not taken his medication. [His] mother believes he is now paranoid and that Natasha was cheating on him. There is also a concern that Natasha faked a pregnancy and miscarriage and that this has triggered the decline in his mental health. Mr L's mother contacted an ambulance as she was concerned for his mental health. Police attended the home address on same day no entry gained as Mr L would not allow access and all individuals were present at the door, all appeared safe and well.

Natasha stated to police that Mr L's behaviour had become nastier towards her because his mental health has been declining. Police opinion was that Natasha appeared vulnerable and would not be able to defend herself if Mr L became violent and for this reason [she] was returned to her mother's address

Mr L appeared calm and made no threats to himself or others he felt frustrated that he has not been able to manage his own money. [The rapid assessment] team liaised with police and advised that Mr L could attend the local accident and emergency department where they would talk with him but there was no urgency for him to attend. Discussion took place with Mr L's mother who has explained she has been managing well with support in the past there was no history of self-harm and she agreed to liaise with the crisis team. Police returned later the same day with ambulance service and Mr L presented in the same mannerism and did not wish to have intervention from ambulance service

PPIU sent to: Adult Care for intervention with Natasha, Mental Health service for intervention with Mr L. To whom information was sent in mental health services is not known.

PPIU referral was reviewed by [the] Advanced Practitioner and Duty Manager. There was no additional new information and contact had been made with

Natasha following the [ambulance] referral, and the [public protection unit] had been forwarded by Police to Mental Health already so decision made that the referral could be closed with an outcome of [no further action].”

28 November 2016 at 23:22: A 999 call was received from Mr L. He reported that Natasha had been stabbed. He also called for an ambulance.

The police arrived at the scene four minutes later. Emergency resuscitation of Natasha was carried out by police officers for approximately 20 minutes waiting for an ambulance. Resuscitation efforts continued for a further hour before she was taken to hospital by ambulance.

6. Findings of the investigation

This section of the report sets out the assessment of the care and management of Mr L by the various NHS providers involved. It also comments globally on the events of 18 November which is the area of greatest concern to the families of Mr L and Natasha.

The perspectives and opinions presented have been formulated via the following activities:

- assessment of Mr L's early intervention records by an independent experienced early intervention nurse, who currently manages an early intervention team in London
- a range of individual and group interviews with members of the early intervention team who knew Mr L and provided care to him
- an interview with the team member at who provided a counselling service to Natasha, who was in receipt of primary care mental health support
- an interview with the emergency duty team social worker, who was on duty the night of 18 November
- multi-agency round the table reflective learning event, at which there was representation of all agencies involved in the events of 18 November, including frontline practitioners, team leaders, as well as safeguarding leads, and senior managers. The advocate for Natasha's mother was present at this meeting, alongside the chair of the domestic homicide review.

Additionally, professionals' perspectives have been provided by service managers in each of the relevant agencies which has assisted the overall formulation of the authors understanding of this case.

6.1 What aspects of the care and management of Mr L and Natasha was managed well

6.1.1 The NHS mental health trust

Between 2013 and July 2016 Mr L's care was reasonable. There were aspects that could and should have been better, including CPA, and the zoning (addressed in the following section). However, there is evidence that care coordinator 1 had a good relationship with Mr L's parents, and they report having had faith in her. It seems she managed to engage with Mr L, in spite of his reticence regarding mental health services per se.

Care coordinators 2 and 3 also demonstrate their commitment to working constructively with Mr L and his parents. Care coordinator 2 was more successful in this, even though she left the early intervention team shortly after becoming Mr L's care coordinator.

When Mr L's care coordinator was changed, the clinical records show that the required standard of handover was delivered, with the outgoing care coordinator and the incoming care coordinator both meeting with Mr L and his mother at her home, which was the usual meeting venue for the service with Mr L. This standard was not repeated in relation to the handover between care coordinators 2 and 3, or 3 and 4. The reason for this was that the outgoing care coordinator had left the service before the replacement care coordinator had been appointed.

Medication management:

It is difficult to see what more the early intervention team could have done with regards to achieving a consistency of medication with Mr L. They tried him on depot medication, but Mr L always drew back from this. Without the necessary factors being present to enable an assessment under the Mental Health Act (1983 updated 2007), and the threshold for a community treatment order not being met, the only lever for the team was one of continual persuasion. The clinical records demonstrate that the team continually made attempts to get Mr L to take his medication

6.1.2 The primary care counselling service

In 2016, the Psychological Wellbeing Practitioner worked with Natasha from March 2016 to July 2016, when Natasha disengaged from their service. The focus of the support sessions was to help Natasha cope with symptoms of anxiety and depression, triggered by ill health in a family member and her frustrations in not being heard by close family regarding her suggestions of support for the family member. Natasha did disclose some suicide ideation in this early contact, but also that she had no intent to act on these thoughts.

Protective mechanisms were discussed, including:

- presenting at A&E
- using the Samaritans helpline
- attending at her GP practice.

Because of this first assessment, Natasha was placed on the waiting list for ongoing 'face to face' support from the counselling team. Owing to the demands on community based psychological support services, this did not happen until 26 May 2016.

The notes made by the Psychological Wellbeing Practitioner, and her conversation with the independent review team, indicated that Natasha engaged well and was open with the practitioner assigned to support her; revealing that she had stopped her anti-depressant medication because it made her feel tired, and that her anxieties had remained unchanged since March.

The Practitioner undertook to complete the Patient Health Questionnaire⁸ with Natasha, a recognised tool for assessing the severity of depression in an individual. Natasha scored 18 on this tool, indicating that she had moderately severe depression at that time. However, the underlying features of this were

⁸ <https://patient.info/doctor/patient-health-questionnaire-phq-9>

considered to be manageable via a range of cognitive interventions, with which Natasha was willing to engage.

The Practitioner encouraged Natasha to continue using the gym, as this would help her endorphin levels, and also provided her with a sleep CD to aid with this. Natasha's aims for herself were to:

- feel happier
- to 'go out' more
- to feel confident about herself,

The Practitioner could not recall the precise detail of the work she did with Natasha, given the passage of time, but she could recall that Natasha reported having an active life previously and that she was no longer pursuing her activities. What the Practitioner was clear about was the use of behavioural activation therapy⁹. One of the activities Natasha would have done is to maintain a behavioural diary, in which she maintained a log of her activities, then, during the session with her therapist, this would form the focal point for discussion.

Her Practitioner recalled that, during the short time she supported Natasha, she did 'come out of herself' more, whereas during the first contacts eye contact was limited. The Practitioner recalls that Natasha also smiled more.

During the third session (30 June 2016), the Practitioner noted that Natasha had not completed her 'home tasks' (this is work such as mindfulness that an individual will be asked to do in between sessions). Natasha was also unable to engage with the agenda for that session as she was upset by a relationship breakup. Although the Practitioner dedicated their session to giving Natasha time to talk about this, Mr L's name was not mentioned, though she and the independent reviewers have presumed that it was Mr L, based on triangulation evidence from the mental health record.

Natasha's Psychological Wellbeing Practitioner stated with clarity that Natasha never talked about Mr L in their sessions. The dominant content was about her family. There was nothing shared by Natasha that gave the Psychological Wellbeing Practitioner any concerns about Natasha's safety.

The meeting on 30 June was the last contact the counselling service had with Natasha. She cancelled further appointments, which coincided with the discovery of her pregnancy in July.

6.1.3 The Ambulance Service

The Ambulance service were only involved in the antecedent chronology leading to Natasha's death on 18 November 2016. From the point at which a call was first placed to them, to the point at which one of their crews attended at

⁹ It is one of many functional analytic psychotherapies which are based on a Skinnerian psychological model of behavior change, generally referred to as applied behavior analysis. This area is also a part of what is called clinical behavior analysis and makes up one of the most effective practices in the professional practice of behavior analysis. For more information: <http://www.talkingsense.org/how-we-can-help/our-therapy/individual-therapy/behavioural-activation/>

Mr L's house to make a determination regarding Mr L's presentation and the need, or not, for a more specialist mental health assessment, the service acted appropriately and in line with their policies and procedures.

It was a period of many hours from the first call to attendance at Mr L's home that night. This was because of the high volume of calls experienced. Rightly, the service responded to the life-threatening cases first, which was why the green rated call relating to Mr L took so long to be responded to.

The chronology shows that the ambulance service remained engaged in the scenario. At just after 9pm, when the ambulance service spoke again with Mr L's mother, they contacted the police directly because of what they heard in the background; including a woman screaming, a man, presumed to be Mr L, sounding very paranoid to the extent that his mother had to leave the building to complete her call to the ambulance service. It was because of the ambulance service's due diligence that the police attended at the home of Mr L, and the safe escort of his mother and Natasha was achieved that evening.

These features meant that the ambulance service was not prepared to close the case until a crew had attended in a clinical capacity, to assess whether it was safe for Mr L to remain at home without any mental health intervention that night.

Although the paramedics and Emergency Technicians are not psychiatrically trained, they are trained in the basics of assessing mental state and they attend significant numbers of call outs that have a mental health component. They are, therefore, able to judge if a patient needs to be transported to hospital for a more detailed mental health assessment.

It was not until midnight that an ambulance crew was able to attend at Mr L's home, with police in attendance to support them, in view of Mr L's history and the recent events of the evening.

It was at this stage that the management team for the ambulance service consider their service could have performed better, the detail of this is set out in the next section of the report.

6.1.4 The emergency duty team

The customer services team and the social worker, on 'emergency duty' the night of 18 November 2016, were the only representatives of adult services that had contact with Mr L's family. No contact with Mr L occurred.

The social worker on duty spoke with Mr L's mother on three occasions during the night of the 18 November, but did not himself attend at Mr L's house, or arrange for a specialist mental health assessment of Mr L. The social worker involved considers that he acted correctly in the context of his work that evening and the situation described to him by Mr L's mother. However, the overwhelming professional opinion is that the duty social worker could have done more than he did that night to achieve a specialist assessment of Mr L; either that night, or in the days subsequent to this. This will be discussed in the next section of the report.

With regards to the subsequent contact between adult social care and Natasha, this was reasonable. It was established that Natasha was at her mother's house and that she had no intention of going back to live with Mr L until he was receiving professional help from mental health services. It was also established that she did not require further support at that time, and was advised what to do if she changed her mind.

Given that she was saying 'all the right things', coming across as sensible, and that this was the first contact she had with adult social care in the context of possible domestic abuse, it is difficult to see what other concrete actions the adult social care service could have carried out for Natasha at this time.

Concerning the issue of Mr L, there is an improvement opportunity for the way the service responds to domestic abuse concerns, with specific regard to:

- the issue of the steps taken to assess mental health
- reengagement with services cases where both individuals are involved or have recent engagement with specialist health and/or social care services.

6.2 The aspects of the care and management of Mr L and Natasha that should have been better

There are no aspects of the care and management of Natasha, by the counselling service, that the independent process has identified as requiring improvement. The professionals who met with Natasha delivered a good service within the time constraints imposed.

There were however, several aspects of Mr L's management that could, and should, have been better than they were.

6.2.1 The NHS mental health service

The core aspects of care and management that fell below the expected standards required were:

- the lack of effective handover of care coordination responsibility between care coordinator 2 and care coordinator 3, and care coordinator 3 and care coordinator 4
- the assessment of Mr L's risks and the ineffective utilisation of what is called 'zoning',
- a missed opportunity for raising a safeguarding alert in July 2015
- the discharge of Mr L from the early intervention team, with specific reference to the:
 - discharge itself
 - non-engagement with Mr L's parents as active partners in the discharge
 - crisis management plan.

6.2.1.1 The ineffective handover between care coordinators 2 and 3, and 3 and 4.

It is a core part of the care programme approach that at the points of discharging a person from a service, or handing over care coordination responsibility, the handover process must be underpinned by comprehensive sharing of information; including background details, relapse signatures, risks, key interventions, medication, and aims and objectives of care.

This did not occur between care coordinator 2 and care coordinator 3. It also did not occur between care coordinator 3 and care coordinator 4. The main reason practice standards lapsed appears to have been as a result of care coordinators 2 and 3 having left the early intervention team prior to the reallocation of care coordination responsibility. This meant they were no longer working for the team when the new care coordinators were appointed. Normally, in such circumstances, the team leader would absorb this responsibility. However, at the time it seems that the early intervention team were in flux, with a lack of clear leadership owing to ill health.

Prior to the commencement of this independent process, the team had been allocated an interim part-time team leader to provide it with the stability the team required. Although this individual's assessment of the team was one with close working relationships, that was supportive of each other, with generally good standards of record keeping and practice, she also identified "that the principles and application of CPA and section 117 responsibilities were not comprehensively understood by the team and were not embedded in practice. Discharges and reviews were generally conducted with the client, care co-ordinator and consultant with limited consideration given to inviting the family, GP and other carers and agencies involved in the client's care. Discharges were not planned appropriately and did not consistently follow the principles and guidance of CPA."

This observation of the interim-team leader, coupled with what the early intervention team told the independent investigation team at interview, enables an understanding of how Mr L's parents were excluded from the discharge planning process. The care coordinator responsible at this stage (4) also advised the independent team that he had newly joined the team from the forensic service, where they were precise about confidentiality. In his experience, a service user would normally give their express consent for sharing information with other family members or significant others. When he took over as care coordinator in the weeks leading to Mr L's discharge from the early intervention service, he had read Mr L's records to inform himself of the history, risks, and current situation etc, and nowhere did he see any formalised consent provided by Mr L allowing him to divulge information to his parents; therefore, he did not share any. Had there been anything in the records that indicated that Mr L had given his express consent for information sharing then he would have done so. Had he been able to have a constructive conversation with Mr L himself, it is more than likely that his approach to the discharge planning would have naturally involved his parents, as he now appreciates, because most meetings with Mr L occurred at his parents' home. However, Mr L was clear in his wish for no communication with the early intervention team and did not engage in constructive conversation.

6.2.1.2 The assessment of Mr L's risks and the ineffective utilisation of 'zoning',

Overall, Mr L presented with low level risks associated with his alcohol intake. There were, however, two incidents in 2016 which ought to have prompted a more careful assessment of him in respect of the risks he posed to himself or others. There was one incident in 2015 which indicated a transitory rise in Mr L's risks, which related to an altercation he had with his parents over money; during which he assaulted his father and was arrested by the police (no charges were pursued).

The next significant behavioural incident was on 13 July 2016. Mr L was disengaging from the early intervention team and did not attend at his mother's house to meet with care coordinator 3. She and Mr L's mother went to his home to see if he was there. On arrival, the scene they encountered was one indicative of deteriorating mental health and excessive alcohol intake. Natasha was present and pregnant.

Care coordinator 3 managed the situation on the ground well. This was her first community based post. When Mr L was refusing to speak with anyone, or get out of bed, she went to his room to speak with him about his current situation. The records also show that she spoke frankly with Natasha, advising her that when Mr L was drinking alcohol in excess that she ought not to be around him. The records show that Natasha told care coordinator 3 that she would not be living with Mr L. The records also show that care coordinator 3 told Mr L the risks to fatherhood and his contact with his child if he continued to drink harmfully. Care coordinator 3, on this day, noted that she would progress a safeguarding referral.

It is also noteworthy that care coordinator 3 had increased Mr L's risk categorisation from the green, low risk, zone to the amber, medium risk, zone because of his erratic approach with his medications and his low engagement with the service. The independent team were somewhat surprised that, following the events of 13 July, he was not escalated to the red zone. His behaviours were visibly deteriorating, and his desire to have no contact with mental health services was more strongly stated. Furthermore, he was in a relationship with a young woman who herself was vulnerable.

Care coordinator 3 told the independent team that she had considered raising Mr L's profile at the zoning meeting. She had previously tried to do this and had been advised that they only discussed service users ranked as high risk. She felt this had been communicated in a way that deterred her from speaking further at the meeting. One of the Band 6 registered mental health nurses has confirmed that it is possible care coordinator 3 found staff a bit gruff with her. At the time, care coordinator 3 had some memory retention and concentration issues that were not known about or understood by the wider team. Consequently, they developed a low tolerance level for what appeared to be repetitive questions asked by her. This coupled with a misunderstanding of how zoning was effectively used led to Mr L's risks not being reviewed by the team as they should have been.

The interim team manager had identified issues relating to practice around zoning and risk management. The independent team asked this individual to set down her observations and reflections, and what actions were being taken to improve practice. Her narrative revealed: "Zoning was undertaken every morning, however, only clients who were placed in the Red zone were discussed. The meeting took place in the largest of the staff offices at desks with other staff stood around, and there was noticeably no zoning board. At that time, there was limited discussion about the clients placed in Red zone, and often it was identified that there was "no change". The team did not discuss clients placed in any other zones and risks were not discussed in any detail. There was no discussion around risk formulation, nor was there any discussion about any changes required to care plans to manage the identified risks and to enable positive change to occur".

A significant influencing factor to zoning not being applied as it ought to have been by the team was a lack of:

- standard operating policy for this process across the Trust
- trust wide training and ongoing assessment of practice.

The lack of accurate application of zoning principles and practice was not because of a lack of commitment in the early intervention team. The senior nursing staff who led this process believed that they were doing it correctly.

6.2.1.3 A missed opportunity for raising a safeguarding alert in July 2015

Linked with the above was a missed opportunity for making an early safeguarding referral for Natasha in respect of her pregnancy and the safety of the unborn child, considering Mr L's deteriorating mental health.

At interview, care coordinator 3 was consistent in her assertion that it was her intent to do this. On discussion with more experienced and senior colleagues she was advised that this was not necessary, as Mr L was making no threats towards Natasha. The independent team asked a band 6 nurse, who gave advice to care coordinator 3, about this and she was equally clear that her advice was to proceed with the referral. It is inconceivable to her that she would have advised differently; she knew Mr L, as she had been his initial care coordinator (care coordinator 1) and the behaviours displayed on 13 July demonstrated a significant deterioration, in her experience of him. The fact that Natasha was in the first trimester of her pregnancy underlined the need for a safeguarding referral.

How the miscommunication occurred between care coordinator 3 and her colleagues is not fully understood. Some factors are thought to have been:

- personality issues among some team members at the time
- a lack of team tolerance for the concentration and memory issues being experienced by Care coordinator 3 over this time
- the concentration and memory issues being experienced by care coordinator 3, resulting in a sometimes-muddled recall of information or advice she had been given.

The interim team manager reported that her initial impressions about the team's approach to safeguarding were that they generally made appropriate

referrals around safeguarding, both for adults and children. However, they were not always fully aware of the risks, especially around the impact of mental health on safeguarding children.

Note: there have been a range of stories about Natasha's pregnancy since the commencement of the domestic homicide review process. It seems that Natasha may not have been pregnant in July 2016. There is clinical information available that indicates a positive pregnancy test, and then subsequent tests indicating that she had miscarried at an early stage in her first trimester. The facts of what happened cannot be determined as Natasha is no longer able to share these. Whether she was, or was not, pregnant does not materially affect the required consideration of the safeguarding actions. At the time staff believed Natasha to be pregnant, and that was sufficient.

In the context of losing the unborn child, and at such an early stage in pregnancy, it is very unlikely that any safeguarding actions would have been taken even had a referral been made.

6.2.1.4 The discharge of Mr L from the early intervention team

There are two aspects to this, the discharge itself, and the non-engagement with Mr L's parents as active partners in this and the crisis management plan.

At the time, the early intervention team considered there was no option but to discharge Mr L. Reasonable effort had been made to try and conduct a CPA handover with the relevant community mental health team, but Mr L did not attend those meetings. It would not be customary anywhere for a community mental health team to accept a new patient without being able to assess them. Furthermore, Mr L himself made clear his wish to be discharged from the early intervention service, back to his GP.

The issue regarding the lack of engagement with Mr L's parents has been attended to in section 6.2.1.1 of this report. There is however, another issue to consider. That is whether Mr L ought to have been discharged from the team at all.

The independent team, the service manager for the early intervention service, and the Trust's patient safety lead consider that had the local and corporate approach to zoning been working as it should, Mr L would not have been discharged as he was. There was sufficient information available to suggest he ought to have been retained by the team and an assessment of his mental health state achieved, via the Mental Health Act if necessary.

This consideration is important, as it presents a realistic opportunity for a different chronology to have emerged over the months of October and November. That is not to say that the incident with Natasha could have been avoided, but it does mean there would have been a continuing surveillance of Mr L's mental health presentation, leading to enhanced clarity regarding his mental health state. It also means it is more likely than not, that a robust response would have been made in the days following the events of 18 November 2016. This, on the balance of probabilities, would have included an

assessment of Mr L under the Mental Health Act (1983 updated 2007) if he remained unwilling to allow mental health professionals to assess him.

Significant contributors to Mr L not being retained by the team are:

- standardised practice in early intervention services, to discharge to a community mental health team or GP at the end of the three-year contact period
- the incomplete application of zoning and risk management practices within the Trust and early intervention team at the time.

Of these, the most significant was the lack of effective utilisation of zoning principles and practice.

6.2.1.5 The decision not to arrange for an assessment of Mr L at his home during the night of 18 November 2016

On the night in question, the duty social worker was working in what is termed a 'lone working' capacity. He was the only social worker on duty for the borough covering adults and, thus, was taking receipt of all emergency calls pertaining to adult social care. There was another social worker on duty acting similarly for children's social care.

During the night of 18 November, there were 10 referrals to adult social care, of which three were classified as high risk.

Time referred	Referral type	Time spent (mins)	Rated
16:45	Request to progress Sec 5:2 to Sec 2	20	Low
16:45	Request for Sect 2 on the ward – passed to AMHP Sat 19th	10	Low
16:48	Call centre referred concerns raised by Mr L's mother and call made to her by social worker		High
17:00	Welfare visit request over weekend – elderly female	10	Low
17:51	Homeless referral from Crisis team	25	Medium
18:32	Homeless referral (service user self-referral)	20	Medium
19:20	Follow up call to Mr L's mother		High
21:24	Homeless referral from police female fleeing DV	40	High
22:00	The ambulance service contacted EDT re. escalation of concern regarding Mr L		High
22:30	Follow up call to Mr L's Mother		High
22:59	Self-referral – suicidal male	45 mins	High
02:15	Referral for 136	30 mins	Low
05:20	Update on 136	10 mins	Low

The total time spent attending to the calls relating to Mr L was two-and-a-half hours.

The line manager for the duty social worker was asked whether it was possible for the duty social worker to have attended at Mr L's home that evening. Her response was: "It's difficult to judge as an outsider what one would have done on the evening without being in the throes of other work coming through whilst also taking into account the conversation with police that Mr L's presentation had calmed down. However, I think on the face of it when this was first referred at 16.45 knowing the police were attempting to visit the property at some point that evening, given the presenting situation I would have attempted to try and co-ordinate an assessment with them and establish [doctor's] availability. The other work could have been picked up on return to office, although we can't predict what other emergencies may have filtered through. Also, [we need] to consider the amount of time the [Mr L's] assessment may have taken/bed issues etc. that could have delayed other work being completed to time scales i.e. homeless pregnant female at 21:24 and suicidal male referred at 22.59. Had he gone out these may not have been dealt with in timely fashion.

I also think had it not been possible to arrange an assessment that evening I would have most definitely passed this on to the next AMHP on Saturday morning to pick up, if only to speak with the [mother] and obtain her views of [her son's] presentation the day after and whether she was likely to see him over the weekend, establish when he was last seen by GP or any other professional, I wouldn't have closed it down completely."

The perspective of the social worker's line manager is echoed by all professional groups involved in this case, as well as by the independent mental health advisor to the author of this report.

Looking at how the situation unfolded over the night of 18 November, it seems that Mr L calmed quickly after the first referral was received. There was a concerning telephone call at 21:00, which was recorded by the ambulance service. On arrival, the police assessed both the situation and Mr L as calm. It is unlikely, therefore, that a Mental Health Act assessment would have been pursued that night, but onwards referral and follow up was required.

The question, then, is why the duty social worker did not read the situation similarly on the night. At interview, the information he provided makes clear that he was concerned about the case and, therefore, advised Mr L's mother to call an ambulance. He was, he asserted, aware that the ambulance service would seek the support of the police.

Other factors influencing the duty social workers perspectives and actions on 18 November were:

- Mr L was at home, safe, and not posing a present threat, as he was on his own; there were no concerns about his immediate personal safety
- if police and ambulance arrived at Mr L's home and he refused transportation to hospital, and appeared mentally unwell, this would have triggered communication either with the control centre at the ambulance service and further communication with the emergency duty team, and/or a call to the rapid assessment team in the emergency

suite at the local accident and emergency, who would have provided advice

- without the police in attendance, based on the history he had obtained from Mr L's mother, the social worker would not have been able to do anything and, as he was working in a lone-worker capacity that night. it made more sense for him to wait to see how the situation unfolded
- the social worker checked the adult social care system, ALLIS, for information about Mr L; there was none. The next steps are to check the mental health system. PARIS. However, the social worker had no access to PARIS that night. This was because either i) he had not had to access the mental health system in four weeks and/or ii) he had not updated his password. If one does not access PARIS every 30 days, then one is automatically locked out of the system. Normally, in this circumstance, the social worker would seek information from the crisis team who are located next door to the emergency duty team. However, on that night there was no-one available, so this was not possible. On discussion, the social worker agreed that he could, with the benefit of hindsight have contacted the rapid assessment team, however, in his experience, to do so would be unusual.

Part of the investigation process was a multi-agency round-table event which included representation from:

- the local county council
- the local mental health NHS Trust
- the regional ambulance Service
- the advocate for Natasha's family
- the local police service
- the local clinical commissioning group.

This event raised a number of issues:

- why Mr L's mum was recommended to call an ambulance – for what purpose?
- why the request of the nearest relative (Mr L's mother) for a Mental Health Act assessment of her son was not recognised by the emergency duty social worker.

The recommendation to call an ambulance was made during the first telephone call the emergency duty social worker had with Mr L's mother, at 17:10 on 18 November, which was 20 minutes after the customer services call centre referred the call to him. In this 20-minute period Mr L had calmed; Mr L's mother advised the duty social worker of this. At this point Mr L's mother continued to assert that her son required hospitalisation, for treatment and to be recommenced on his medication.

Although the duty social worker believes his decision to advise her to call an ambulance at this stage was reasonable, he is the only professional involved in this case who has this perspective.

A range of professionals, including the independent advisor to the author of this report, consider better approaches would have been to:

- arrange an assessment of Mr L by the emergency duty team social worker, with the support of the police and possibly the duty GP; there were sufficient features of concern to have justified this
- request the out of hours doctor to attend at Mr L's home with police support
- once the police had attended because of a concern about risk escalation at 21:00, due to potential risk to Natasha and Mr L's mother, and on the police's decision to leave Mr L at home because he seemed calm and no action was required by them, to have suggested that Mr L's mother encourage Mr L to go to A&E for an assessment either via taxi or home transport (low probability of success)
- with Mr L's consent, an access and crisis assessment could have been initiated (low probability of success)
- across the multi-agency community there is a general sense that it was not appropriate for the ambulance service to have been 'left holding the fort' regarding trying to gain a clinical insight to Mr L's mental health state, given the complexity of the situation.

Regarding the non-action in response to a request from the nearest relative, a key concern for a range of professionals from these agencies was why the duty social worker had not recognised the request by Mr L's mother as a nearest relative request for assessment, that her son be detained in hospital. The emergency duty team professional was unable to interpret the request in this way, and unable to appreciate what seemed plain to other professionals in the room, that Mr L's mother wanted her son assessed.

This gap in professional opinion remains at the time of writing. Despite this difference of opinion, the realistic timing of such an assessment is less clear. Reviewing the chronology as it unfolded that evening, there was no urgency to conduct a specialist assessment of Mr L that night, and it is unlikely that he would have allowed a Mental Health Act team into his home. His presentation, whilst paranoid, was calm, and it is unlikely that an application for a warrant to enter his home would have been made that night.

What is more likely, and represents what should have occurred, is:

- mechanisms ought to have been put in place to ensure the follow up of Mr L the following day, to try and gain a better insight as to his mental state
- based on the reported history, if he continued to refuse access to enable this to happen, then serious consideration should have been given to achieving this via the conduct of a Mental Health Act assessment (1983 updated 2007), under warrant and with police support.

That no mechanism was put in place to ensure that further attempts were made to assess and clarify Mr L's mental state, represents a serious breach in safe practice procedure.

The team manager for the emergency duty team was asked about the options for onwards referral, specifically when an individual requires assessment but it is not achieved within the span of duty for the emergency duty professional.

The author of this report was also interested in referral routes for emergency duty staff.

The following information was received from the team manager for the emergency duty team, and is relevant to the understanding of what was, and was not, possible on the night of 18 November, and in the days after. The emergency duty team do not have a direct referral pathway to GP surgeries. Ordinarily, emergency duty team staff would signpost a service user to make an appointment to see their GP if the initial referral to emergency duty team was considered not to be an emergency.

In this case, although recommending self-referral to the GP was unlikely to be effective for Mr L, it was possible for the emergency duty team social worker to have made a record on ALLIS, that primary care follow up was required, but that adult care needed to initiate contact with the GP surgery, owing to the high risk of Mr L not doing so. The Adult Care duty worker would then read this at the start of normal business hours and follow up actions as requested by the emergency duty worker.

The emergency duty worker also has the option to discuss cases with the rapid assessment team, where people present as requiring a mental health assessment (not Mental Health Act Assessment). However, there are no direct referral pathways to the rapid assessment team, other than advising a patient to present at A & E for assessment. The rapid assessment team will see a person after they have been triaged by A & E staff, should this be necessary.

The emergency duty team are aware of the street triage function, however, there are no current pathways for the emergency duty worker to refer to this service, other than directing people/patients to A & E, where they will be triaged first via A & E liaison and referred to rapid assessment/Street Triage if appropriate. It is the understanding of the independent author that the police have strong links with street triage; where police become involved in incidents in the community, or in a public place, where people are found to be mentally unwell/high risk to self and others, police can consider contacting street triage (attached to rapid assessment team) to discuss their views and arrange an assessment. This meets the guiding principles of the Mental Health Act 1983 (as revised 2007) use of least restrictive options and intercepting the use of police powers under Section 136. Although it is not established practice for emergency duty team (EDT) professionals to contact the rapid assessment team, had there been a consideration of this, to access relevant information about Mr L, then the EDT practitioner would have been able to access his PARIS records. This would have revealed Mr L's past history, and most recent history, and may have influenced a different level of response to that which occurred on 18 November 2016.

Technically, there was the option of assessment by the crisis team. However, this would have had to have been achieved by 21:00, and Mr L was unlikely to have provided his consent for this given his refusal to engage with the police or the ambulance service that night. Furthermore, because the referral met

the grounds for a Mental Health Act assessment, this would have exceeded the remit of the access and crisis team.

The manager agrees that considering the information communicated by Mr L's mother, and her son's apparent calmness, as considered by the police, an emergency Mental Health Act assessment may not have been necessary on the night of 18 November. However, a range of actions should have been taken including:

- setting down in writing for Mr L's mother, as nearest relative, the reasons why a Mental Health Act assessment was not conducted on the night she requested it, and why no recommendation was being made for it
- keeping the referral open on the emergency duty system and signposted to the Approved Mental Health professional, who would have picked it up the following day, on a handover, at 08:00 on 19 November
- emailing the referral to the emergency duty community teams centralised address, for the attention of the duty Approved Mental Health Professional on Monday 21 November
- the emergency duty social worker could have assigned the notification to the adult duty tray for Monday 21 November. Although this social worker did add a case note it was not assigned to the tray. This meant it was not read by the adult care duty worker.

Even if a decision was made that a Mental Health Act assessment was not required, there would have been the opportunity for a referral to be made to Mr L's GP or to the community mental health team or early intervention team.

6.2.1.6 The attendance of the regional ambulance service at Mr L's home at approximately 2am on 19 November 2016

The ambulance service was only involved with Natasha's and Mr L's pre-incident chronology on 18 November 2016. The actions of this service were mostly reasonable and in keeping with their policies and procedures, including how calls are prioritised and responded to. In many respects, one can consider that a good level of service was provided to Mr L by this service. All other involved agencies had stood down once Natasha was away from Mr L's home and safely transported to her mother's home. However, because of the history initially provided to the ambulance service, the call was maintained as requiring a response, until someone had been able to determine whether a specialist mental health assessment was required that shift, the night of 18 – 19 November.

The ambulance service managed to dispatch a vehicle to attend at Mr L's home at 22:51, with it being at the rendezvous point at 00:02. The crew were being accompanied by police colleagues.

The statement obtained from one of the attending ambulance technicians advises that when the ambulance crew and police attended, Mr L came to the door. Because of the passage of time, the ambulance technician was only able to recall that:

- Mr L's demeanour did not cause her any undue concern

- there was nothing 'out of the ordinary or unusual about him'.

The technician reported that she was certain that she would have acted if there had been anything untoward or concerning. The technician is also clear that neither she, nor her colleague, would have left the scene if they had any concerns about Mr L; that would be her usual practice. Unfortunately, no patient report form is available to set out the precise details of this crew's attendance at Mr L's home. The technician is adamant that she would have completed this as it is part of a crew's normal practice following each attendance. An audit of the crew's patient report forms for the shift in question was requested by the author of this report, and showed that the report form relating to Mr L was the only one missing from the patient contacts on that shift. It seems more likely than not that, owing to the non-contact with Mr L other than brief words on his door step, no form was completed, or it was mislaid prior to being submitted with all the other forms.

The professional advisor to the domestic homicide review panel considers that there was a lapse in standards by the crew, as they ought to have contacted the control room to seek advice when it was clear that they could not achieve a meaningful assessment of Mr L. The history provided by his mother was significant; a recording of contact with Mr L's mother at 21:00 on 18 November demonstrated that Mr L could be heard in the background and was clearly paranoid to the extent that his mother had to leave the house to complete her call to the service.

The duty social worker considers that, had he been aware that the ambulance service had not been able to gain sufficient access to Mr L to form an informed opinion regarding his presentation, he would have organised an assessment under the Mental Health Act, with police assistance.

7. Learning Opportunities

The learning opportunities listed below represent issues that require an uplift in professional knowledge, insight, and behaviour. Addressing these factors is notoriously difficult. The author of this report asks the involved agencies to bring together staff that work in the areas identified, to involve them in designing an improvement plan that is deliverable and has some features of sustainability and measurability, in terms of 'demonstrating' improvement in the immediate, medium, and longer term.

Learning opportunity 1

Mr L's drinking habits were a perpetual problem. To enable an achievable harm reduction strategy, it is useful if clinicians find out more detailed information about a person's pattern of drinking, including:

- the percentage alcohol beer/larger being consumed
- the can size being consumed.

These factors can make a significant difference, and slight alterations, such as reducing the percentage alcohol and/or can size, can make a positive difference.

Target agencies: NHS, Adult Social Care.

Learning opportunity 2

There are a range of support networks for families and friends of problem drinkers. There is no indication, in this case, that Mr L's parents, or Natasha, were advised of these. Given the enabling role friends, family, and partners often hold, not only is it beneficial to the non-drinker to receive support, support provided to significant others can enable them to change their behaviours around the drinker. This can have a positive impact on the drinker and result in a reduction in the harmful behaviour. The Trust and the local borough county council needs to set out how it will enhance the education of educates its staff in such matters, and how it will enhance promotion of such networks to families, carers and partners.

Target agencies: NHS, Adult Social Care.

Learning opportunity 3

Where there are domestic abuse concerns about a partner/carer, and they have given verbal reassurances that they are going to keep themselves safe and stay away from a 'risky individual', then suddenly change their minds, prudence requires that the care coordinator needs to try and create a situation where he/she can speak with the partner/carer on their own to understand what has triggered their change of mind.

Target agencies: Although this issue arose in the NHS, it is of equal relevance to all sectors working with individuals who may be abused or where there are professional concerns about this.

Learning opportunity 4

No agency was identified as the communication hub during the management of events on the night of 18 November 2016. As the concern was one of a deteriorating mental state, it seems logical that the emergency duty team needed to act as the communication hub in this case. On a more reflective note could the emergency duty team have undertaken the initial liaison with the ambulance service about the need to assess the home scenario with Mr L, rather than asking Mr L's mother to do this? This may have resulted in a more cohesive response.

Note: developments within the ambulance service mean that it can now refer directly to the crisis team if it is concerned about an individual, as it was in the case of Mr L.

Target agencies: the Borough County Council.

Learning opportunity 5

On 23 November, adult social care had a conversation with Natasha during which she advised she would not be returning to live with Mr L unless he engaged with mental health services. Neither her mother nor Mr L's mother would have had any confidence in this assertion had they been aware of it, because of their observed behaviour of Natasha in relation to Mr L. Statutory services have no control over the actions and decisions made by individuals, but what adult social care could have done was to inform Natasha about the website Wellbeing [R] hosted by the local charity MIND. This site has a wealth of information; Natasha needed support in managing and living with a problem drinker as much as living with his mental health disorder. Now it is aware that the information service exists, the borough county council has committed to building on the current knowledge base of support services and multi-agency teams in relation to the resources available to people experiencing domestic violence. The borough county council will also consider establishing lead professionals within the service, and how it can build a stronger awareness of the issues related to domestic abuse; including recognition that power and control issues may prevent a person accepting support when initially offered. The borough county council informed the independent author that it recognises the importance of proactively ensuring that the victim and his/her family have knowledge of sources of information about where support can be accessed for them at a further point in time. This includes building strong links with the local NHS mental health service, independent domestic violence advocacy services, housing, and the prevention team.

Target agencies: although this issue arose in adult social care, it is of equal relevance to all sectors working with individuals who may be abused, or where there are professional concerns about this.

Learning opportunity 6

The ineffective zoning of Mr L, in terms of his increasing risk factors, and the lack of oversight of his 'amber' zone status, is a recognised learning point for the involved team and the Trust, at the time Mr L was a service user there was no clear organisational approach to zoning, and no audit of practice. The learning that has emerged from this independent review process alongside

previous recognition in the Trust of the need to develop practice and enhance knowledge in relation to zoning is already being implemented with the development of a corporate standard, training for all staff using zoning, and audit of practice.

Target Audience: the NHS mental health provider.

Learning Opportunity 7

In the early intervention records reviewed, there was a lack of clarity regarding the recording of the efforts and interventions offered, such as:

- family intervention work
- access to Mr L for the supported employment programme
- the undertaking of physical health assessment
- carer-focussed education and support programme.

These are now NHS England Commission for Quality and Innovation targets, which are designed to achieve transparency and an overall improvement in healthcare. The narrative style records used up to 2016, and the design of mental health review document, meant that it was not clear to what extent the above quality indicators were being delivered. This particularly relates to the 2015 – 2016 care period, after care coordinator 1 had taken a secondment elsewhere.

Target Audience: the NHS mental health provider.

Learning Opportunity 8

The meeting requested by Mr L highlighted two NICE quality standards and early intervention standards. These are:

- Statement 3. Family members of adults with psychosis or schizophrenia are offered family intervention.
- Statement 8. Carers of adults with psychosis or schizophrenia are offered carer focused education and support programmes

A question was also raised regarding the standard timeframe for joint working a patient being transferred to a community mental health team from early intervention services.

To find out what the current picture in the Trust was the patient safety lead for the mental health trust contacted the responsible service managers. The key ongoing areas for improvement arising from this are:

- To achieve consistency of approach and reliability in the provision of family, or partner, focused education and support across the Trust's early intervention services
- To achieve a deliverable standard of handover / joint working time between teams when a service user is being transferred. This requires different services to come together to explore how consistency and reliability can be achieved. Identifying a fixed timespan in a policy document will not achieve the aspired principle of effective handover of care and continuing engagement of the service user.

Target audience: The patient safety lead in the Trust and the service leads for early intervention and community mental health teams

8. Improvements and changes already instituted by the agencies because of this case, or other quality and safety improvement initiatives

The local authority Emergency Duty Team (EDT)

It had not been made clear until following this review whether EDT can refer to Access and Crisis and what the correct process was. The manager of the emergency duty team and the social worker involved in this case now understand, from meeting with the Access and Crisis Manager, that where EDT staff believe the criteria is met for Access and Crisis, and the referral does not meet Mental Health Act Assessment (MHAA) criteria, they can complete an Access/Crisis referral form, and pass to the Access team who will screen it and feedback whether they agree, or not, that it meets their criteria. The person being referred must consent to the assessment before the referral can be made. However, if the person lacks capacity to consent, Adult Care duty team are to be informed – EDT are to assign to Adult Care tray on ALLIS and or consider MHAA.

Note: there remains a lack of clarity about a service user's need to consent for referral. This has arisen in a previous mental health homicide review in Bury and a considered opinion is that the consent of the service user is not required for referral. If a service user is offered an appointment but does not engage this can be considered a tacit withdrawal of consent.

The local council

The local council is committed to developing a joint action plan with the local mental health trust to ensure that all emergency duty team staff have access to the mental health system out of hours.

Towards the end of 2017, for operational reasons, a decision was made by Children's Services, who host the emergency duty team for adults and children for a neighbouring council, to manage the emergency duty team in the local authority in which the incident occurred. The social care manager and the head of service for mental health of the local authority work in partnership to provide weekly support to the emergency duty team manager to quality assure cases/processes. The local authority has also commissioned the social care manager to undertake a rolling programme of training to the approved mental health professionals of the emergency duty team, in recognition of their lone working situation, and in recognition that there is a high turnover of staff in this team.

Adult Care are progressing a Business Case for an out of hours manager cover effective from 1 May 2018. This is in recognition of the lone working situation for the approved mental health professionals covering the out of hours emergency duty rota.

Adult Care are extending staff knowledge of the resources available to support families experiencing domestic abuse. This includes raising awareness of local support groups and leaving the door open for service users/carers/families to come back for support at a time that is right for them.

Further training is also planned around substance misuse and the link to domestic abuse as well as creating professional champions in this area.

Finally, the local authority continues to consider how best to deliver its emergency duty team services. The location of the emergency duty team service will be fully considered as part of the service transformation

The mental health trust patient safety team:

The Trust has already commenced work on resolving the password access issue for professionals working in adult social care who require access to the PARIS records to deliver safe care. The recommendation around this issue remains in the report as the work is ongoing, notably to determine whether or not there is a failsafe option.

As part of this work, the Trust's patient safety lead will review the interface with the five Boroughs Councils Emergency Duty Teams to establish if there are communication problems in relation to accessing electronic mental health records per se. If there are, then an action will fall to the newly appointed Associate Director roles within the Boroughs to work with their Local Authority partners via an established partnership meeting or Local Care Organisation meeting to ensure that communication between agencies for patients in mental health crisis is effective, efficient and embedded.

The Early Intervention Service

The interim team manager for this service was asked by the independent author to set out changes that have occurred in this team since the inception of this independent process. She reported the following:

Zoning

The interim manager requested full team training and refresher training from the Trust patient safety lead on how to zone effectively, using principles of risk management; this was delivered and led to a much greater clarity of understanding of escalation, increased support, and how risk management drives the clinical decision-making, rather than being 'reactive decision-making'. The interim manager reported: "This has now been reviewed and occurs twice a week. The venue has changed to the meeting room, which enables full participation of all staff without distractions of computers and phones. A board is used as a visual prompt with further laminated prompts outlining the criteria for each zone. The consultant psychiatrist is involved and actively contributes to zoning and the principles of zoning are adhered to. Appointments are offered to clients who are zoned into red as a result of deteriorating mental health in the urgent clinics which have now been agreed. The Criminal Justice Mental Health Team regularly attend and actively contribute to these meetings enhancing further discussions around risk formulation and management. All red, amber and black clients are discussed with action plans and team discussions to ensure that risk is recognised, understood and managed appropriately. The team are also encouraged to raise concerns regarding anyone they may have in green zone that they believe may need to be managed differently or there are concerns, and they may need to be moved into another zone. Clients are now moved around in

zoning which wasn't happening previously, and team discussions enable a fuller and comprehensive risk plan to be formulated.

The staff have responded positively to these changes and this has resulted in an increase in incident reports being submitted, thus demonstrating better and more effective safety cultures, and increased, enhanced critical thinking. This is demonstrated within zoning sessions and supervision sessions. Zoning is now embedded within the supervision process and the staff are demonstrating a positive understanding of effective risk management. Staff are aware that risk management plans and care plans should be updated accordingly along with the zoning process. Supervision is now being used to cross-check with individual practitioners their actions from zoning and on-going case management.”

Care Programme Approach

The interim manager said:

“It was initially apparent that the principles and application of CPA and section 117 responsibilities were not comprehensively understood by the team and were not embedded in practice. Discharges and reviews were generally conducted with the client, care co-ordinator and consultant with limited consideration given to inviting the family, GP and other carers and agencies involved in the client's care. Discharges were not planned appropriately and did not consistently follow the principles and guidance of CPA.

As a team we have reviewed the CPA and section 117 policies and the team are now clear on the principles and the application of these and are arranging comprehensive reviews and discharge planning meetings appropriately. There has been an agreement with the Community Mental Health Team that all cases suitable for transfer to them will be jointly managed and reviewed for a period of up to 3 months, to enable a smoother transition period for the client and family/carers and to ensure that there is a comprehensive understanding of the patient's needs. Clients discharged back to the care of their GP are provided with an updated crisis plan ensuring that relapse prevention and early warning indicators are identified with a clear management plan to follow if required. This plan will be shared with the GP Family and carers (with consent). Developments are continuing in enhancing effective collaborative care planning and meaningful engagement; the Trust is piloting new care planning and risk assessment forms”.

Risk Assessment

The interim manager said:

“Although risk assessments were being completed they were not as robust as they should be and not always recognising the actual risk and the risk formulation was not always documented. Risk assessments were not always updated as risk changed.

The team have now been trained in bespoke higher risk management formulation and have demonstrated a good understanding of risk formulation. This learning and development will continue to progress through supervision and through the team case formulation meetings. The team are more risk aware and the zoning process is having a positive impact on this. The team

are being encouraged to ensure both the care plan and risk management plan are used as working tools and updated regularly as an individual's needs and risk changes. Staff are now aware of how to input safety alerts into the system and how to contact the security manager to ensure that these alerts are inputted into other systems. Moving forward the team will be encouraged and supported to seek wider sources of information in relation to longitudinal risk via other agencies or internally (e.g. from the Risk Department)".

"In addition, the early intervention team will be moving to the new Trust Risk Assessment for community mental health and early intervention team services, prior to the publication of this independent report. The rationale for this is: the tool that has been distilled from a version of the in-patient one developed by risk and safety specialists within the Trust. It went through a rigorous development process before being signed off for in-patient use. The trust took the decision to review the old approach because:

- aggregated learning from incident reports that revealed incomplete documentation of risk
- 20 years of national confidential inquiry into suicide and homicide data advised providers to move toward a more formulaic approach, with the service user more central to the process
- feedback from colleagues that the length of the Trust's previous risk approach was overwhelming.

The in-patient pilot has been extremely well received by CCG and CQC reviewers. Furthermore, staff on in-patient units report it is a better way of describing and formulating risk for a patient. I suspect that we can build reviewing in as part of the next audit cycle of risk assessments. The Trust has shared the documents it is implementing with the team at that national confidential inquiry into suicide and homicide office, who are undertaking a review of all risk assessment tools from around the UK."

Observation by the independent author

The above represents improvement work of direct relevance to this tragic case. Improvements that extend beyond the boundaries of this case review have also been accomplished. The early intervention team, the interim manager, and patient safety team at the local NHS mental health service are complimented on accepting the necessity for immediate improvements to occur and ensuring that these have been delivered within such short timescales.

The Ambulance Service

The ambulance service has implemented a structured triage service across its geography, which is mapped to GP catchments. In the town in which the homicide occurred, individuals who are: "experiencing an episode" or "who denote amber pathfinder outcome" can be considered for referral to the mobile mental health team. This means, unlike in November 2016, a mental health professional, will assess the information passed to them and attend to the patient to conduct an assessment if they deem it necessary.

9. Outstanding actions required

The NHS mental health service

Because of the sizable commitment demonstrated in the Trust to improving standards in the early intervention service, and the positive response of the staff working in that service to more active frontline management than they have been accustomed to, alongside the corporate commitment to ensuring there are common standards around CPA, CPA plus, risk assessment, and zoning, the author of this report has no additional priority recommendations to make.

The learning points identified in this report do, however, need to be considered, with a response provided to NHS England as to how these principles of practice are to be incorporated into everyday practice.

The mental health trust and local borough county council

The location of the emergency duty team

The one issue arising from this case that cannot be allowed to continue is the lone working situation for adult and children's emergency duty teams. How these teams can be co-located with other out of hours mental health teams must be explored. It simply does not make logical sense for them to be geographically separate.

Access to the NHS mental health records

The current situation where a social worker's access to NHS mental health records is terminated, either because they have not accessed these in a set number of days, or because they have forgotten to update their password (for which there is no reminder system), needs to be reviewed and remedied.

It ought to be technically possible for the password renewal system to operate on the same timescales as for NHS.net, and for local authority staff to have their daily work email address logged as the repository for any automated reminder emails.

In the circumstance where a social worker has forgotten to update their password, or has simply forgotten it, the feasibility of an automated reset system needs to be explored.

If the emergency duty team were collocated with other mental health services, the above problem would disappear.

10. Conclusions

This is a tragic case, as every needless loss of life is.

The care and management of Mr L was, for the most part, reasonable, but with perpetual scope for improvement in relation to:

- care programme approach
- risk assessment
- zoning (a colour coded approach to prioritising higher risk patients).

From July 2016, there were clear signs that Mr L's mental health was deteriorating. He was on what is termed the 'amber zone' of the risk categorisation used by the early intervention service. Optimal management would have been to place him in the higher risk red zone. This did not happen.

One reason for this was the lack of assertiveness in care coordinator 3 in insisting that Mr L's case was discussed at the zoning meeting. This lack of assertiveness was the result of her experience of been told that only service users already in the red zone could be discussed. This is contrary to reassurance provided by the consultant psychiatrist to the Trust's investigation team that team members were able to raise concerns about risk, even if the threshold for the red zone had not been reached. That Mr L's case was not discussed was a significant contributory factor in continuing with the plan to discharge him from the service. This process was concluded in the first week of November 2016.

On 18 November 2016, Mr L's mother reported a significant deterioration in her son. Her concern was such that she contacted the emergency duty team in the borough county council. The duty social worker concurred that her concerns were well placed and advised her to contact the ambulance service. On balance, it is agreed that this was an erroneous judgement; the social worker ought to have contacted the duty GP and attended at Mr L's home himself to assess the situation with police support, as it had been reported that Mr L had access to a knife and had recently threatened his girlfriend with it. The local authority is conducting a separate capability review with the practitioner because of what happened.

It is also agreed that if it were not possible to conduct a visit that evening, or if the urgency for this was reduced because Mr L's mother, at a later point, reported a calming in her son, then an assessment of Mr L should have been highlighted as required within the next few days. This may have included an assessment under the Mental Health Act (1983 updated 2007) if Mr L did not agree to being assessed voluntarily.

The team manager of the early intervention service at the time told the report author that had they been aware of the events of 18 November they would have i) attended at Mr L's home to try and assess him and ii) if he refused to be assessed would have organised an assessment under the Mental Health Act. A warrant authorising entry to Mr L's home would also have been applied for.

Had any of the above occurred, there is a realistic possibility that the subsequent sequence of events would have been different, and Mr L may have become fully, or partially, re-engaged with a mental health team and medication. This means that it is possible that the death of Natasha may have been avoidable. There are no guarantees, but the missed opportunities in the months and weeks close to the time of the incident are such that 'potential avoidability' must be accepted.