

VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of

Mr D

A report for
NHS England, South Region

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Introduction

1.1 Background to the independent investigation

Mr D, a 37-year-old service user under the care of Kent and Medway NHS and Social Care Partnership Trust (the trust) attacked a 58-year-old (fellow resident of his shared community accommodation) on 6 March 2011. The man died from his injuries two days later.

Mr D was arrested, charged and remanded in custody at HMP Elmley.

Mr D pleaded guilty to manslaughter at Maidstone Crown Court on 30 August 2011 and was detained under the Mental Health Act (MHA) 1983, in October 2011. He was subsequently transferred to the Trevor Gibbens Unit¹.

Mr D informed a psychiatrist (conducting a pre-sentence report for this offence) that his mental health first deteriorated when he was 21 years old, following a nine-month prison sentence. He said that he began to hear voices, and following an inpatient admission four years later was diagnosed with paranoid schizophrenia. He recalled being treated initially with clozapine. He was then treated with another anti-psychotic medication (Clopixol) given as a fortnightly injection (depot medication). He was compliant with his depot medication at the time of the offence.

The chief executive of the trust commissioned a management clinical serious incident learning review (SI review) into the care and management of Mr D. The SI review was carried out by a service manager and a quality assurance manager. It is not clear from their report whether they met Mr D, his family or the victim's family during their review.

The SI review team submitted a first draft of the report in July 2011. The final report was submitted in December 2011 and made six recommendations.

NHS England, South Region, commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out this independent investigation. Our investigation commenced at the end of March 2014.

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

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

¹ The Trevor Gibbens Unit provides medium secure care (assessment, treatment and rehabilitation) for men and women. The unit has 65 beds. The unit is run by Kent and Medway NHS & Social Care Partnership Trust.

This report also includes a follow-up review of a previous homicide investigation that concerned the same trust services in Thanet.

Amber Sargent, senior investigator for Verita and Geoff Brennan, associate, carried out the investigation. Their biographies can be found at appendix A.

Tariq Hussain, senior consultant, peer reviewed this report.

1.2 Overview of the trust

The trust was formed on 1 April 2006 after East Kent NHS and Social Care Partnership Trust and West Kent NHS and Social Care Trust merged. The trust provides mental health, learning disability, substance misuse and other specialist services for 1.6 million people across Kent and Medway.

2. Terms of reference

The terms of reference for the independent investigation, set by NHS England (South), in consultation with Kent and Medway NHS and Social Care Partnership Trust, are as set out below.

2.1 Purpose of the investigation

To identify whether there were any aspects of the care Mr D received which could have been predicted or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents from occurring.

The overall aim is to identify common risks, best practice and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

2.2 Terms of reference

- Review the assessment, treatment and care that Mr D received from Kent and Medway NHS and Social Care Partnership Trust up to the time of the incident.
- Review the care planning and risk assessment, policy and procedures and compliance with national standards.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
- Review the documentation and recording of key information.
- Review the communication, case management and care delivery.
- To consider the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan and identify:
 - if the internal investigation satisfied its own terms of reference;
 - if all key issues and lessons have been identified and shared;
 - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
 - review progress made against the action plan; and
 - review processes in place to embed any lessons learnt.
- Review any communication and involvement with families of the victim and perpetrator before and after the incident.
- Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the internal investigation process.

- Review the relevant agencies involvement from Mr D's first contact with services to the time of the offence.
- Consider if this incident was predictable or preventable.
- The independent investigator may consider other issues that warrant further investigation.

3. Executive summary

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

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, Guidance on the discharge of mentally disordered people and their continuing care in the community, and the updated paragraphs 33–36 issued in June 2005.

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

3.1 The incident

Mr D, a 37-year-old service user under the care of Kent and Medway's community recovery service, got into an argument with a 58-year-old man (a fellow resident at Moncrieff House) on 6 March 2011. Mr D had accused the victim of taking his coat and jewellery. The argument escalated and Mr D punched him. The victim allegedly hit his head on the side of the doorframe as he fell to the ground, and Mr D was believed to have then stamped on his head. The victim was taken to King's College Hospital with serious head injuries and died two days later.

Mr D was remanded in custody at HMP Elmley. He pleaded guilty to manslaughter at Maidstone Crown Court on 30 August 2011 and was sentenced in October. He was detained under the Mental Health Act (MHA) and moved to the Trevor Gibbens Unit, a medium secure inpatient unit.

3.2 Overview of care and treatment

Mr D was under the care of the trust from the early 1990s. In 1995 Mr D was twice admitted to hospital under a MHA Section 2 after exhibiting paranoia and delusions.

He was admitted to hospital under Section 2 of the MHA a further three times between 1996 and 2000. He remained in hospital for much of 2001 and was admitted for fast-stream rehabilitation at the Grove¹ in December 2002. He had already been diagnosed with schizophrenia (in 1996). He was discharged in August 2003 and moved to supported housing at the Christian Housing Trust.

¹ The Grove is a mixed-gender inpatient mental health rehabilitation unit for up to eight adults situated in Ramsgate. It aims to provide intensive support to adults with complex mental health issues and a high level of psychological need for up to a year. The unit is staffed by nursing and support staff, with support from medical, psychological, and occupational therapy teams.

At this point, Mr D's care was moved to the assertive outreach team (AOT). He was prescribed clozapine and was monitored through a clozapine clinic in the Westbrook Centre (run by the trust).

Following three further inpatient admissions (September 2002, March 2004 and November 2004) due to non-compliance with his medication (because it made him vomit), Mr D's consultant changed his medication to another anti-psychotic. Mr D was started on a Clopixol depot anti-psychotic on 11 November 2004.

By June 2005 Mr D's consultant considered him to be "doing very well". A care programme approach (CPA) review in November 2005 described Mr D as being "in a settled state".

Mr D's care was reviewed under CPA on:

- 26 June 2006;
- 24 November 2006; and
- 21 September 2007.

During this time he continued to live in supported accommodation with the Christian Housing Trust. He continued to comply with his depot medication and had regular contact with AOT keyworker 1.

Between 2008 and 2009 Mr D was without a care coordinator. He was not reviewed under CPA despite receiving treatment from the trust for a severe mental disorder.

Mr D was seen by mental health workers on 27 August 2009, 2 September 2009, 8 October 2009 and 23 October 2009. He was also seen in outpatients on 2 October 2009 by consultant psychiatrist 1.

On 15 March 2010 Mr D was allocated to a social worker, social worker 1. This allocation was to assist Mr D with a forthcoming house move as his supported accommodation through the Christian Housing Trust was closing.

Social worker 1 helped Mr D to find alternative accommodation at Moncrieff House. Although he was due to move on 29 March, this was delayed and Mr D spent some time in the Hailey, which was a supported living environment. The records indicate that he settled well into the Hailey. During this time, Mr D was given his depot injection at his accommodation.

Mr D was again without a care coordinator, but this was not picked up. There was confusion because nurse 1, the main nurse who administered Mr D's depot, was recorded in the electronic records as being Mr D's care coordinator although it was clear in our interview with her that this had not been discussed with her. In addition, senior social worker practitioner 1 whom nurse 1 considered to be Mr D's care coordinator, has no recollection of being allocated Mr D.

At the time of the incident, Mr D was compliant with his depot medication. He received his last injection two days before the offence. No concerns were raised during this appointment.

3.3 Overall conclusions of the independent investigation

Several important aspects could have changed the way trust services engaged with Mr D. Despite this, we found nothing to suggest that this incident was predictable or preventable.

Trust staff undertook limited risk assessments in Mr D's case. His risk was not reviewed regularly or at pivotal points – such as following his move from supported to unsupported accommodation – in his engagement with trust services. This practice was not in line with national or trust policy and could be considered poor.

Greater recognition that Mr D's attendance at the depot clinic was his only contact with trust services (particularly in the last year) could have helped to ensure that his care was appropriately managed and that his engagement was suitably therapeutic.

Mr D's clinical notes indicate that his mental health had been stable for several years – primarily as a result of his compliance with his depot medication. Instances when it was considered that Mr D might be becoming unwell were often picked up by support staff at Christian Housing. It was documented in Mr D's records that he was unlikely to alert services himself if he was unwell. This demonstrated the important role that housing played in Mr D's care.

Mr D had to move accommodation because the Christian Housing Trust was closing. In March 2010 social worker 1, from the recovery team, was allocated to support Mr D in finding new accommodation. Social worker 1 completed CPA documentation, including a care plan, risk and needs assessment for Mr D. In the assessment social worker 1 wrote that Mr D had difficulty with self-care and needed to live in supported accommodation to manage his needs.

Despite this, Mr D was placed in unsupported accommodation. We can find no reference in Mr D's clinical records to the reason for this.

Given that Mr D was moved to unsupported accommodation, we would have expected a greater level of monitoring of the effectiveness and suitability of the placement. This should have included a risk assessment being completed after the move and clear documentation of the risk indicators. We can find no evidence of such monitoring or assessment in Mr D's clinical records.

Additionally, there is nothing in Mr D's clinical records to suggest that there was any recognition by mental health staff that Mr D was now living in unsupported accommodation and therefore may have needed a greater level of input.

At that time, there was no policy detailing how the depot clinic should function or what the expectations were of the level of engagement between staff and service users. Having no guidance on the role of depot clinics was poor practice and a sign

of poor clinical management and leadership. It resulted in staff not being clear about expectations of their role with service users.

It was not clear who Mr D's care coordinator was once he moved to Moncrieff House and therefore who was ultimately responsible for his care planning, risk management and management of any issues as they arose. During his depot appointments, Mr D raised concerns about his accommodation and particularly about his possessions being stolen. His clinical records suggest that the staff member who gave Mr D his depot recorded Mr D's concerns and passed them on to his care coordinator. However, in view of the confusion about who his care coordinator was, it is unlikely that these would have been acted upon. Certainly, there is nothing in clinical records to indicate that action was taken, for example to review the suitability of Mr D's accommodation.

The trust delegated its responsibility to monitor Mr D's mental health to visiting housing staff. There is no evidence in the clinical notes that any meaningful discussion took place between housing and trust staff. This could have potentially resulted in deterioration in Mr D's mental health not being identified in a timely way.

3.4 Recommendations

R1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.

R2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.

R3 The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertakes an audit to ensure compliance with the new guidance.

R4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months.

4. Approach and structure

4.1 Approach to the investigation

This investigation was undertaken in private. It comprised a review of documents, four interviews and a focus group with seven members of staff from Thanet community recovery services. We used information from Mr D's clinical records and evidence gathered from the internal management clinical learning review. As part of our investigation we interviewed:

- nurse 1, community psychiatric nurse (CPN);
- service manager 1;
- senior social worker practitioner, social worker; and
- assistant director 1.

We had full access to trust papers produced at the time of its internal management clinical learning review.

We wrote to Mr D at the outset of the investigation, explained the nature of our work and asked to meet him. We subsequently met him at the Trevor Gibbens Unit, Kent. Mr D gave written consent for us to access his medical and other records. We told him that the report was likely to be published.

Mr D did not want us to meet with or communicate with any of his family as part of this investigation.

We contacted the victim's son via the police liaison officer involved in the case. We subsequently met with the son and explained the purpose of our investigation and the process followed. We also gave him the opportunity to share any information with us.

Our findings from interviews and documents are in ordinary text and our comments and opinions are separated out. This does not apply in section 6, which consists largely of comment and opinion.

4.2 Structure of this report

Section 5 sets out the details of the care and treatment of Mr D. We have included a chronology of his care in order to provide the context in which he was known to trust services.

Section 6 examines the themes arising from Mr D's care and treatment.

Section 7 reviews the trust's internal investigation and reports on the progress made in tackling the organisational and operational matters identified.

Section 8 sets out our overall analysis and recommendations.

5. The care and treatment of Mr D

5.1 Early years

According to a psychiatric report completed after the offence, Mr D was born and raised in Margate, Kent. He grew up with his mother, father and brother. He travelled abroad extensively as a child due to his father being in the army but returned to the UK in 1985 (aged 12).

Mr D attended mainstream school but said that he required extra help in the classroom. He described himself as “a bit of a loner”. He left school with four GCSEs when he was 15.

5.2 Forensic history

Prior to this offence Mr D had 11 convictions for 23 offences, which include five offences against the person, three offences against property, nine thefts and kindred other offences, five offences relating to police, courts and prison and one firearm (shotgun) offensive weapon offence.

He served two custodial sentences in a youth offending institute (one of six months and one of nine months). He also received four conditional discharges, two community services orders and was fined on three occasions.

His offences that would be considered violent in nature (possession of a firearm, assault occasioning actual bodily harm, common assault and wounding) occurred between 1991 and 1999 (when he was between 18 and 26 years old). There is no evidence of him being involved with the police between 1999 and this offence in 2011.

5.3 Contact with mental health services

5.3.1 1995–2000

The trust’s internal investigation report says that Mr D first came into contact with mental health services in 1998 (when he was 25 years old). However, a psychiatric report compiled after the incident suggests that Mr D was admitted to a hospital in the trust under Section 2¹ of the Mental Health Act with a diagnosis of paranoid psychosis between 28 May and 19 June 1995. Following discharge from hospital he was followed up in the outpatient department.

On 24 December 1995 Mr D was placed under Section 136 of the Mental Health Act in Gatwick Airport as he was claiming to be the Messiah. He was taken to Ashford where he was detained under Section 2 of the Mental Health Act. He absconded from the ward after four days and was not located before his section lapsed. He was discharged in his absence.

¹ A Section 2 is detention in hospital for assessment

Mr D had a further inpatient admission to the trust under Section 2 of the Mental Health Act in December 1996. His clinical records state that he was diagnosed with schizophrenia and that he showed little insight into his mental health problems. He was treated and discharged back to the care of his GP (within the Kent community) with a follow-up psychiatric outpatient appointment to monitor his medication use.

On 17 July 1998 Mr D was again admitted to the trust under Section 2 of the Mental Health Act. This was converted to a Section 3¹ on 10 August. Mr D's Section 3 was "withdrawn" by a consultant on 18 September 1998 and Mr D discharged himself the next day. Mr D was discharged back to his GP with outpatient appointments scheduled with a psychiatrist.

On 9 November 1999 Mr D's brother wrote a letter to the GP warning that Mr D was delusional, living rough and relying on charity to survive. The letter was forwarded to the day-centre consultant psychiatrist in Kent. On 29 November the GP rang the police to ask them to consider taking Mr D into mental health services for an assessment on a Section 136² if they see him. We have no information about what happened following this request.

In April 2000 Mr D was seen by his GP and threatened to "shoot the police if I saw them". He also said he would shoot the GP if this happened. His family requested police involvement. Given Mr D's history with guns, a tactical response unit was used to locate him and take him to hospital on a Section 136. Mr D was located and admitted to a trust hospital on 8 June 2000.

Comment

It was difficult for services to engage Mr D. In the years between 1995 and 2000 he lacked insight into his mental health problems and was managed by his GP with occasional outpatient appointments. This was not effective in helping him to stay well.

5.3.2 2000-2004

Police took Mr D to hospital under MHA Section 136 in June 2000. He was admitted to Dudley Venables ward, an acute inpatient ward in St Martin's Hospital, Canterbury, where he received treatment and was placed on a MHA Section 3 on 29 June 2000. It is recorded in the clinical records that Mr D assaulted "fellow patients in an unprovoked attack" on three occasions during that inpatient episode.

¹ A Section 3 is an assessment in hospital for treatment.

² The police can use Section 136 of the Mental Health Act to take someone from a public place to a place of safety. They can do this if they think the person has a mental illness and is in need of care. A place of safety can be a hospital or a police station. The police can keep someone under this section for up to 72 hours. During this time, mental health professionals can arrange a Mental Health Act assessment. This will look at if the person needs to be in hospital.

The records are unclear regarding when, but at some point Mr D was transferred to Elmstone ward where he continued treatment. In March 2001 he was prescribed clozapine and it was recorded in his clinical records to “have effected a dramatic change in his mental state”. This change resulted in Mr D being more social and active. On 16 May 2001 a clinical assessment identified that Mr D was being considered for a programme of rehabilitation. Doctor 1 recorded:

“It is our opinion that Mr D has pronounced rehabilitation needs. It is not however clear if Mr D possesses sufficient motivation to be placed in a fast-stream rehabilitation home. His stated aim is to return to living in the woods and his motivation to improve his daily living skills might therefore be poor. However, his keyworker believes that, with encouragement, he might engage in Wellington House for fast-stream rehabilitation.”

Comment

Rehabilitation is a longer-term treatment than the treatment provided for an acute crisis. Rehabilitation is used for those who have long-term mental health problems which are a combination of acute psychotic symptoms when unwell, and also of residual negative symptoms (lack of motivation, apathy and neglect of personal hygiene) which remain when the acute crisis is resolved. Rehabilitation units focus on long-term rehabilitation through social and occupational therapy. At the time that Mr D was engaged with trust services they had fast-stream and slow-stream rehabilitation depending on how disabling the residual symptoms were.

The risk of Mr D returning to vagrancy and self-neglect with little social activity following improvement to his acute mental health crisis would fit in with a diagnosis of a long-term and debilitating mental illness.

At this point in Mr D’s care, the notes we have seen are unclear as to the care that Mr D was given. What seems most likely is that Mr D was discharged at some point in 2002. On 7 January 2002 Mr D was assessed by his then consultant psychiatrists who said at the ward meeting:

“It is clear that Mr D would not participate in the full and energetic programme which is demanded of clients in fast-stream rehabilitation service. As regards alternative placements for Mr D, it is our belief that he should remain on the waiting list for slow-stream rehabilitation. Given the length and delay on this waiting list, and the likely long duration of any [transfer] to the slow-stream rehabilitation units, we wondered if it would be appropriate to consider a supervised discharge for Mr D”.

Mr D was eventually admitted to the Grove unit (a fast-stream rehabilitation unit) on 13 December 2002. He was admitted under MHA Section 3 and remained there until August 2003. Upon discharge he was housed with the Christian Housing Trust. The Christian housing Trust was an organisation that provided supported living.

On Mr D’s discharge from Grove ward, his care was transferred to the assertive outreach team (AOT), which offers contact with clients who are known to be difficult

to engage. Mr D was allocated to AOT keyworker 1. Mr D continued on clozapine in the community. Clozapine requires careful monitoring due to side effects, and Mr D was monitored through a clozapine clinic in the Westbrook Centre in Kent.

Mr D was readmitted to a hospital in the trust under Section 2 of the Mental Health Act on 19 September 2003 owing to his non-compliance with Clozaril. On admission Mr D was not experiencing an acute psychosis but was not taking his medication. Mr D believed that Clozaril was causing him to vomit and he had therefore been reluctant to continue taking it. A discharge CPA meeting¹ was held on 29 September 2003 which was attended by AOT keyworker 1, his assertive outreach care coordinator. He was discharged back to his accommodation at Christian Housing.

On 10 December 2003 Mr D was reviewed by the AOT consultant 1. Mr D was taking his medication, but continued to suffer from vomiting. AOT consultant 1 referred Mr D to the enhanced team² at the Beacon (Thanet Community Mental Health Team) for follow-up. The referral was accepted by the enhancement team. This referral should be seen as a step down in care – a reduction in intensity/frequency of engagement.

By March 2004, clozapine monitoring indicated that Mr D was not taking his medication. He was readmitted to hospital on 15 June, initially under a MHA Section 135³, but this was converted to a MHA Section 2. He was re-established on clozapine. A CPA meeting took place before he was discharged on 1 September 2004 back to his accommodation provided by the Christian Housing Trust.

By October 2004 clozapine monitoring indicated that once again Mr D was not taking his medication. Mr D continued to report that the drug was making him vomit. In November he was admitted to a hospital in the trust following a relapse, although this time it was an informal admission. CPA documentation completed in November 2004 recorded that Mr D's medication was changed to depot due to a history of vomiting and because he found it impossible to sustain suitable therapeutic levels of oral medication.

5.3.3 2005–2007

Mr D remained on Fleet ward (in a Kent hospital). The clinical records state that a period of leave in February 2005 did not go well and that the depot medication was not effective in controlling his psychotic symptoms. Mr D was referred back to and accepted by the AOT by the time the discharge CPA was held in April 2005. He was discharged back to Christian Housing and again allocated AOT keyworker 1 as a keyworker.

¹ These are held to plan for discharge.

² The enhanced team offered support to people with long-term mental health problems, but they offered less contact and monitoring than assertive outreach.

³ The police can use Section 135 of the Mental Health Act to remove a person from a private place to a place of safety. They can do this if they think someone has a mental illness and is in need of care. A place of safety can be a hospital or a police station. The police can keep someone under this section for up to 72 hours.

In June 2005 Mr D was assessed by consultant psychiatrist 2, and was noted to have admitted to using cannabis although he is described as “doing very well”. He was compliant with his depot medication and continued to be monitored by the AOT.

In September 2005 Mr D was the subject of an Adult Protection meeting¹ due to an allegation (made by another service user) that he bought £90 worth of cannabis from a support worker. The outcome of this meeting is not documented in Mr D’s clinical notes.

Mr D had a CPA review on 22 November 2005 which was attended by AOT keyworker 1. The review found that Mr D was “in a settled state” and treatment continued.

Comment

By 2005 Mr D’s various care teams had attempted several different approaches to his medication. Although clozapine was more effective in treating his mental health symptoms, it was obviously not agreeable to Mr D and he was consequently non-compliant. He was seen to be more compliant with the depot anti-psychotic. The supported living in Christian housing and the AOT were also effective in keeping Mr D engaged and monitored for any signs of relapse.

Mr D’s care stabilised and he was reviewed under the CPA on:

- 26 June 2006;
- 24 November 2006; and
- 21 September 2007.

During this time he continued to live in supported accommodation with Christian Housing, he continued to comply with his depot medication and had regular contact with AOT keyworker 1. Mr D continued his regular contact with AOT keyworker 1, but the notes contain little detail of their engagement.

5.3.4 2008–2011

On 27 August 2008 the team secretary for the continuing treatment² team recorded that Mr D had turned up asking for a doctor’s appointment and she noticed that he hadn’t had a CPA review since 2007. There is no evidence in the records that a CPA review subsequently took place.

¹ An adult protection meeting is arranged if there are concerns that a service user is not safe or that someone is causing them harm.

² NHS continuing healthcare is care outside of the traditional hospital environment, provided over an extended period to a person aged 18 or over, that is arranged and funded by the NHS. To be eligible for NHS continuing healthcare, the person must be assessed as having a “primary health need”, a complex and substantial health or mental health need that has arisen as a result of disability, accident or illness.

On 27 August 2009 the nurse who gave Mr D his depot medication was concerned about him and attempted to contact AOT keyworker 1. Contact was made, but AOT keyworker 1 said that Mr D was referred back to the enhanced team in 2008 and had not been under assertive outreach for “at least a year”.

Comment

A previous investigation that Verita conducted with this trust (into the care and treatment of another service user who was known to the services at the same time as Mr D¹) found that the enhanced team was struggling to cope with the volume of referrals and overall workload. A practice of the team was to accept a referral and, if a care coordinator could not be allocated, to leave the referral for one of the senior practitioners to allocate. In this way it was possible for a referral to be accepted even if there was no care coordinator to take the case.

At the time that Mr D was without a care coordinator he was being given regular depot injections. We have seen no record that the workers who gave his injections tried to contact his care coordinator before 27 August.

Mr D was seen by community mental health team (CMHT) staff on 27 August, 2 September, 8 October and 23 October 2009. He was also seen in outpatients on 2 October 2009 by consultant psychiatrist 1. Consultant psychiatrist 1 noted that the plan was for Mr D to remain on medication and:

“To contact duty should he need some support in between appointments now that he has been discharged from the assertive outreach team to the care of the enhanced team.”

Comment

It remained unclear who Mr D’s allocated care coordinator was at that time.

Consultant psychiatrist 1 reviewed Mr D in his outpatient clinic on 2 October 2009. Mr D reported that he had been hearing voices and that he was not sleeping well. He also expressed some thoughts of being agitated and restless. However, consultant psychiatrist 1 did not consider that Mr D presented any risks. The plan was for Mr D to continue with his medication (Clopixol) and to be reviewed again in six months.

In March 2010 Mr D was taken to see Moncrieff House as his current accommodation (Christian Housing) was closing down. Moncrieff House was an unstaffed housing project.

Social worker 1, from the recovery team, was allocated to support Mr D in finding new accommodation. Social worker 1 completed CPA documentation, including a care plan and needs assessment for Mr D. In the assessment social worker 1 wrote:

¹ See [“Publication of an independent investigation into the care and treatment of Mr G – 23 August 2013.”](#)

Common themes with this investigation are discussed later.

“[Mr D] will need alternative supported accommodation”.

Regarding activities of daily living, social worker 1 concludes that Mr D:

“Has difficulty with self-care and needs to live in supported accommodation to manage his self-care.”

Mr D was set to move on 29 March. This was delayed and Mr D spent some time in the Hailey, a privately owned residential care home. His notes suggest that he settled into the Hailey well. During this time, Mr D was given his depot at his accommodation.

Despite social worker 1's comments in the CPA documentation, Mr D was placed in unsupported accommodation. We found no reference in Mr D's clinical records as to the reason for this.

Mr D moved from the Hailey to Moncrieff House on 10 May 2010. It is unclear from the records what exactly happened next, but it is clear that social worker 1 stopped working with Mr D. In effect, social worker 1 had a very specific role and that was to assist Mr D in finding alternative accommodation. That being done, he had no further contact with him.

In September 2010 nurse 1, a CPN, recorded that Mr D wanted to move from Moncrieff House. Mr D asked again in October 2010. However, no reason for this is recorded.

Mr D started attending the Beacon for depot injections on 22 October 2010. These had mostly been administered at home up until this point.

In December 2010 Mr D told a Beacon staff member that he preferred having his own flat and that he wanted to move.

Mr D was administered his depot injection by nurse 1 on 7 January 2011. Nurse 1 recorded that Mr D continued to be well and settled. However, he sought a move because he wanted greater independence. Otherwise, there were no concerns. Nurse 1 documented that senior social worker practitioner 1 had been notified of Mr D's wishes. However, there is no account of their conversation or agreed actions in Mr D's records.

Mr D's clinical records suggest that he was given his depot injection by a Beacon staff member without incident on 24 January 2011.

On 4 February 2011 Mr D attended the Beacon for his depot injection, which was given without incident by nurse 1. This depot was given earlier than originally scheduled after discussions with the Thanet Community Mental Health Team. Mr D asked again if he could have his own flat, as he had had his watch and a chain stolen at Moncrieff House. There is nothing in the notes to indicate that this information was discussed with other team members.

Mr D attended the Beacon as arranged on 18 February 2011. Nurse 2, a CPN, administered 500mg Clopixol without incident and documented that Mr D reported being unhappy where he was living because his gold (jewellery) had been stolen. Mr D said that he had informed all relevant persons of this. It is not clear from the notes whether Mr D's care coordinator (whoever was shown as being allocated this role in RiO¹) was informed.

On 4 March 2011 Mr D attended for his depot injection, as planned. The injection was administered by nurse 3, a CPN, and his physical observations (blood pressure, etc) were taken. He stated he was "off to a cafe to have a cup of tea"; nothing untoward was reported. This was the first time CT had met Mr D.

Mr D got into an argument with a fellow male resident at Moncrieff House on 6 March 2011. Mr D had accused the other resident of taking his coat and jewellery. The argument escalated and Mr D punched the victim. The victim allegedly hit his head on the side of the doorframe as he fell to the ground. Mr D was believed to have then stamped on the victim's head. The victim was taken to King's College Hospital with a serious head injuries and died two days later.

¹ RiO is a clinical information system used to store electronic patient records securely.

6. Issues arising, comment and analysis

In this section we review the policies and procedures in place in the trust when Mr D was known to the services. We also look at the trust's current policies and procedures and other documentation to establish what improvements have been made since the incident in March 2011. We interviewed senior trust managers who gave us examples of how policies and procedures have been implemented. A full list of the documents reviewed can be found in appendix C.

As this section mainly consists of comment and analysis we have not separated this out from the narrative.

The trust's management clinical learning review concluded that nothing could have been done differently to predict or prevent this incident, and that there was no evidence that it was a result of Mr D's mental health problems. The review did, however, make six recommendations (see section 7). We have taken the findings of the trust's review as a starting point and built on their findings. We also focus on the points identified in the terms of reference for our independent investigation and further areas that have emerged during our investigation. We have not undertaken an independent audit of developments in the service or the implementation of the trust's serious incident (SI) review recommendations but rely on information provided by the trust and information gained in the focus group we held.

We set out our analysis under headings for the terms of reference for this investigation.

6.1 Whether the assessment, treatment and care that Mr D received from Kent and Medway NHS and Social Care Partnership Trust up to the time of the incident, including whether the care planning and risk assessment, policy and procedures complied with national standards

6.1.1 Level of support

The trust's care pathways policy (incorporating CPA) dated April 2010 incorporates arrangements for two types of support:

“CPA Care Pathway for people with complex characteristics, who are at higher risk, and need support from multiple agencies”;

and:

“Care Pathway for people with more straightforward support needs... care and support should be proportionate to need and people may move from one type of support to another at different times”.

The policy was compiled on the basis of national guidance and the Department of Health's refocusing CPA guidance¹.

¹ Refocusing CPA, Putting People First (DH 2007) and High Quality Care for All (DH 2008).

Based on the national guidelines it was likely that Mr D would be considered as suitable to remain on CPA because he:

- was diagnosed as having a severe mental disorder (schizophrenia); and
- tended to neglect himself and did not take treatment regularly.

6.1.2 Review arrangements

The trust's care pathways policy states that a review of needs is ongoing and that a formal multi-disciplinary review will take place at least once a year, but is likely to be needed more regularly.

In the early years (1995–2000) it was difficult for services to engage Mr D in his care and treatment. He lacked insight into his mental health problems and was managed by his GP with occasional outpatient appointments. At times he deteriorated to the point where he would need hospital admission; he would then be stabilised (often as a result of restarting his medication) and then discharged back to the care of his GP. This was not effective in helping him to stay well.

CPA reviews took place in:

- November 2004;
- February 2005;
- November 2005;
- 26 June 2006;
- 24 November 2006; and
- 21 September 2007.

In August 2008 the team secretary for the continuing treatment team noticed that Mr D had not had a CPA review since 2007. However, this did not result in a review taking place. The fact that Mr D's CPA was not reviewed between September 2007 and March 2010 meant that he was not managed in line with CPA requirements.

The next time CPA documentation was completed was in March 2010, when social worker 1 was supporting Mr D in finding new accommodation. There was no indication that Mr D was under ongoing CPA arrangements or that he had an allocated care coordinator in line with the care pathways policy.

Social worker 1 helped Mr D to find alternative accommodation at Moncrieff House. Although Mr D was set to move on 29 March, this was delayed and Mr D spent some time in the Hailey. The records indicate that he settled in there well. During this time, Mr D was given his depot injection at his accommodation.

Mr D moved from the Hailey to Moncrieff on 10 May 2010. Again it is unclear from the records what exactly happened next, but it is clear that social worker 1 stopped working with Mr D. In effect social worker 1 had a very specific role and that was to assist Mr D in finding alternative accommodation. That being done, he no longer had contact with him.

Mr D was again without a care coordinator, but this was not picked up. There is confusion because the main nurse who administered Mr D's depot (nurse 1), is, we are informed, recorded on the electronic records as being Mr D's care coordinator although it was clear in our interview with her that this had not been discussed with her. In addition, senior social worker practitioner 1, who nurse 1 considers to be Mr D's care coordinator, has no recollection of being allocated Mr D. Senior social worker practitioner informed us that this may have been the same systems error as noted in the comment on pages 22-23 of our report. She told us:

"Thinking back to 2011, Thanet was potentially running with quite high sickness rates, there would have been, because there was a reorganisation and Thanet North and Thanet South amalgamated and we moved into recovery and access, there was a reorganisation around office duty. There were lots of reorganisations around that time. What tended to be the practice, if it was an unallocated case, then it would be put in a senior's name, because it couldn't just sit there with no name attached to it. If there is evidence that I am care coordinator that might be where that has come from."

Mr D's most regular and consistent contact with the trust's services between 2004 and 2011 was when receiving his depot medication.

The trust should have ensured that these contacts were feeding into Mr D's care in a systematic way that would have provided an opportunity to check that he understood who was coordinating his care.

Finding 1

It is not clear from Mr D's clinical records whether he was receiving CPA support for complex or straightforward needs. Based on our review of his care we believe he was eligible for complex CPA.

Recommendation

R1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.

Finding 2

Mr D was effectively without a care coordinator (when under the enhanced team in 2008–2009) and following his placement in Moncrieff House in May 2010. His only regular contact with trust staff was when he received his depot medication.

The suitability of Mr D's placement at Moncrieff House is explored later in this section.

6.1.3 Risk assessment

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. The trust's policy states that:

“Risk assessment is an essential part of an assessment. Like all other forms of assessment it is a continuous process”.

It also says that care plans should:

“Incorporate risk management plans based on risk assessment”,

and that:

“All risk assessments and risk management plans should be regularly reviewed... the risk management plan should be formally reviewed, signed and dated as part of the preparation for each review meeting”.

In Mr D's case there is little evidence to suggest that risk was assessed routinely, in line with the trust's policy. His last risk assessment took place in April 2010 when social worker 1 was seeking new accommodation for him. A risk assessment and risk management plan should have been formulated to monitor Mr D's move from supported to unsupported accommodation.

6.1.4 History of violence

Mr D's clinical records record his history of violence as follows:

June 2000:

“[Mr D] attacked fellow patient in an unprovoked attack”.

Also that month:

“He started to throw punches at [staff member] which were blocked and resulted in [Mr D] being restrained and moved to the seclusion room”.

August 2001:

“Mr D shouting and punching [X] in the kitchen”.

Contributory factors were recorded as:

“Misunderstanding plus [Mr D] always hungry as he is in bed all day”.

A tribunal report states:

“There is concern that [Mr D] has the potential for violent behaviour. His response to questions is cursory without evidence of thought disorder, but he continues to be paranoid”.

The report also notes that when Mr D was first admitted to Dudley Venables House¹ he presented as hostile and threatening:

“While there, he was secluded on two occasions for attacking other patients. Once transferred back to Thanet, he attacked another patient and... has on two or three occasions demonstrated aggressive and threatening behaviour”.

Doctor 1 recorded Mr D’s progress as an inpatient in January 2002:

“There has only been one episode of violence over the last eight months when [Mr D] punched somebody who he believed was trying to steal his plate of food”.

There is nothing in Mr D’s clinical records to indicate that he behaved violently between 2002 and the offence in 2011. However, when Mr D began to report that his property was being taken from Moncrieff House there was no consideration of how he might behave/react in such a situation. His CPA documentation was not reviewed in light of his concerns about the theft and wanting to move accommodation.

Risk assessments are usually considered part of a dynamic process and should be regularly reviewed and monitored, particularly when there are changes to a patient’s condition or circumstances.

The purpose of a risk assessment is not to predict an incident of violence but to plan what should be done when a patient with a history of violence (and other risk factors) becomes unwell, in order to prevent a similar possible violent incident. It is clear that Mr D had not behaved violently for a significant period of time; however, there is little acknowledgement of his previous violence or an assessment of his propensity to behave violently again in the future.

6.1.5 Risk when moving accommodation

Mr D appeared to be well contained by living in supported accommodation (Christian Housing and then at the Hailey). There is nothing in the notes to suggest that consideration had been given either to the risks associated with moving Mr D from supported accommodation or to the support he might need from mental health services to compensate.

Given that Mr D was moved to unsupported accommodation, we would have expected a greater level of monitoring of the effectiveness and suitability of the placement. This should have included a risk assessment after the move with clear indicators of any signs that Mr D’s health was deteriorating.

Additionally, there is nothing in Mr D’s clinical records to suggest that there was any recognition by mental health staff that Mr D was now living in unsupported accommodation and therefore may have needed a greater level of input.

¹ A mixed-sex acute admission ward that provides care to adults aged 18 to 65 years experiencing mental health difficulties.

6.1.6 Reviewing and recording risk

The trust's internal management clinical SI learning review states:

“No recent risks identified, despite [Mr D's] previous history of violence 11 years ago... The most recent CPA risk assessment was undertaken in April 2010 – before Mr D's move to Moncrieff House. There should have been another review undertaken after he had settled in this accommodation with a CPA2 assessing need and CPA3 providing the plan of care”.

Mr D's risk does not appear to have been considered or documented in the way that it should have been according to national and local guidance.

Social worker 1, completed a CPA2 needs assessment on 23 March 2010. No risks were identified. Although he recorded that Mr D has:

“Difficulty with self-care and needs to live in supported accommodation”.

Social worker 1 completed a risk assessment on 23 April 2010. No current risks to others were identified, although self-neglect risks were highlighted.

Further CPA documentation was completed by social worker 1 on 6 May 2010. No current risks to others were identified, although self-neglect risks were highlighted.

Finding 3

Social worker 1 undertook a risk assessment in April 2010 in which he stated that Mr D needed to live in supported accommodation. Despite this Mr D was moved to unsupported accommodation and there was no justification for this move documented in Mr D's clinical records.

Additionally, Mr D's risk was not reviewed regularly or at pivotal points – such as following his move from supported to unsupported accommodation. This practice was not in line with national or trust policy and would be considered poor.

Recommendation

R2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.

6.2 Support through depot clinics

The trust's internal investigation report concluded that:

“There is no information recorded regarding the sharing of information from services to the service user. Mr D made use of the clinic to share his

frustrations on at least three occasions, but there is no indication in the records that this information was being acted upon. Mr D mentioned more than once that he did not like Moncrieff House and it could be speculated that he had frustrations about his accommodation which became fuelled by the argument over a jumper... We have been unable to establish how information was passed on to the coordinator. Depot Clinics are run at a variety of locations in Thanet and from these locations there is no RiO access. Information is therefore input at a later time. It was mentioned that all care coordinators struggle to input on ePEX¹/RiO due to time constraints and the availability of computers. There is no evidence from the notes that any advice from the social worker specifically relating to Mr D was acted upon”.

Several issues arise here. Firstly, there was no protocol for how the depot clinic should operate – particularly what was expected of staff in terms of providing for a therapeutic engagement. Secondly, it was not clear who was responsible for coordinating Mr D’s care. Two staff we interviewed both considered that the other held the role of care coordinator in this case and therefore was ultimately responsible for Mr D’s care planning, risk management and managing any issues as they arose.

This is likely to be a result of allocation issues highlighted earlier in this report. Thirdly, staff in the depot clinic did not have access to RiO and therefore there would undoubtedly have been a delay in recording notes following appointments.

It is clear from the notes and interviews that the staff administering depot medication, either in the depot clinic or in the client’s own home, saw their role in very narrow terms and essentially simply to administer the medication. For Mr D these were crucial encounters during which he talked about his concerns.

Mr D’s community care support was therefore managed mostly through the depot clinic. In the year leading up to the incident, that was his only contact with mental health services. At the time of the incident there was no protocol for the running of a depot clinic and therefore it is not clear whether Mr D was receiving a therapeutic intervention when he attended for his injection. These appointments should have been opportunities for staff not only to assess his mental health but also to consider any potential risks and to support Mr D with any issues he raised. In the absence of any effective care coordination or the support of staff in his accommodation looking out for signs that his mental health was deteriorating (he was now living in unsupported accommodation when his risk assessment was that he needed supported accommodation), these depot clinic appointments were even more important.

Finding 4

Having no guidance on the role of depot clinics was poor practice and a sign of poor clinical management and leadership. It resulted in staff not being clear about expectations of their role with service users.

¹ ePEX is an electronic system formerly used by the trust to record clinical notes.

Recommendation

R3 The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertake an audit to ensure compliance with the new guidance.

6.3 The communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment. Review the relevant agencies involvement from Mr D's first contact with services to the time of the offence

Mr D was known to several services and agencies throughout his contact with mental health services. In the year leading up to the offence (March 2010–March 2011) Mr D was engaged with:

- Thanet Community Recovery Service;
- Recovery Depot Clinic (the Beacon);
- Moncrieff House (unstaffed housing project);
- Christian Housing (supported accommodation); and
- Primary care (through his GP).

6.4 Communication between the trust and housing

Mr D lived in supported accommodation through Christian Housing (August 2003–March 2010) and the Hailey (March–May 2010). When Christian Housing closed, Mr D moved to Moncrieff House (after a brief stay at the Hailey while waiting for a room to become available). Moncrieff House is unstaffed and unsupported.

An entry in Mr D's clinical records in August 2009 states:

“It was unusual for... [Mr D] to admit that he wasn't doing very well”.

This suggests that deterioration in Mr D's mental health or general condition was generally picked up by support staff in his accommodation.

CPA documentation from 22 February 2005 records:

“Concerns raised by manager of Christian Housing as [Mr D] was not engaging and appeared agitated”.

A CPA meeting on 24 November 2006 was attended by the home manager who reported concerns about Mr D's poor living conditions, which were attributed to his lack of motivation and low self-esteem.

A note dated 27 August 2009 by a staff member states:

“She [AOT keyworker 1] was surprised that [Mr D] doesn’t seem to have a care coordinator. She said that [Mr D] would never come in of his own accord... it was unusual for [Mr D] to admit that he wasn’t doing very well”.

This statement indicates that staff knew it was unusual for Mr D to alert mental health services when he was unwell. The above examples indicate that it was in fact housing workers who identified when Mr D’s health was deteriorating and notified the relevant services.

There is little reference in Mr D’s clinical records to the quality and frequency of engagement between visiting housing staff and trust staff. There is reference to Mr D attending an appointment for his depot injection with the Moncrieff House home manager, but little evidence that any discussion took place regarding Mr D’s housing, his needs or risk factors.

Finding 5

The trust delegated its responsibility to monitor Mr D’s mental health to visiting housing staff. There is no evidence in the clinical notes that any meaningful discussion took place between housing and trust staff. This could have potentially resulted in any deterioration in Mr D’s mental health going unnoticed.

Recommendation

R4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months.

6.5 Communication between the trust and Mr D’s family

The clinical records suggest that Mr D’s family was involved in his care and treatment in the early years of his engagement with trust services. However, there is no mention, either in the care plans or in the daily records, of any such engagement in more recent years.

6.6 Predictability and preventability

We use the following standards to establish whether the homicide could have been predicted or prevented.

We consider that the homicide would have been predictable if there had been evidence from Mr D’s words, actions or behaviour that could have alerted professionals that he might become violent, even if this evidence had been unnoticed or misunderstood at the time.

We consider that the homicide would have been preventable if there were actions that professionals **should** have taken and which they were able to take to prevent it

and which they did not take. Simply establishing that there were actions that **could** have been taken would not provide evidence of preventability.

6.6.1 Predictability

In the interviews that we have carried out and in our review of the clinical records there were no words, actions or behaviour that could have alerted staff that this tragedy may occur. Mr D was well known to the trust's community mental health services. He had been compliant with his depot injection for a considerable period and engaged appropriately with the service. There was some evidence that Mr D had acted aggressively towards others in the past, however, there had been no recorded incidents in the last nine years. Mr D did raise concerns to trust staff about his accommodation and reported that somebody had been stealing his belongings. Although more could have been done to try to get to the bottom of Mr D's claims and review his housing placement, there was nothing about Mr D's actions or behaviour that led, or should have led, trust staff to believe that such an incident would occur.

6.6.2 Preventability

A social worker assessed Mr D as needing to continue to live in supported accommodation in March 2010. However, without explanation in his care records Mr D moved to unsupported housing. Given this move we would have expected a greater level of monitoring of the effectiveness and suitability of the placement. This should have included a risk assessment being completed after the move and clear documentation of the risk indicators. Despite this omission, we do not consider that this housing placement or lack of monitoring led to the incident. Therefore this tragedy was not preventable by actions that the NHS should have taken.

6.7 New developments or improvements in services since Mr D's engagement with mental health services

6.7.1 Background

On August 2013 NHS England published the report of an independent investigation into the care and treatment of a Mr G. The investigation was also conducted by Verita.

Mr G had been assessed by the Thanet CMHT but never taken on as a client. Mr G was involved in a serious incident on 5 March 2011. This was the day before Mr D attacked the fellow resident in Moncrieff House. The investigation into the care and treatment of Mr G included senior manager interviews and a focus group meeting with the CMHT.

The trust and CMHT have viewed the two cases as linked in that they are contemporaneous and, as mentioned earlier, indicated common themes. One of the recommendations of the Mr G report was that a follow-up review should take place to examine the changes put in place as a result of the report. The analysis of this section is drawn from interviews with managers and the focus group we held. This section relates both to the care of Mr D and to the follow-up review of Mr G.

In both the Mr D and the Mr G cases, one of the themes already discussed was clients not being allocated care co-ordinators for treatment under the Care Programme approach. Other issues for the Thanet CMHT in 2011 were: high case load sizes; low staff morale and a lack of supervisor and managerial support.

“We were told during interviews with trust staff that historically the CMHT did not function well. All cases were allocated to the team manager or a senior practitioner as opposed to individual staff members. This resulted in both individuals having a caseload in excess of 300. There was very little care coordination. Staff reported that morale was low, sickness was high and there was a lack of supervision and managerial support” (Mr G report, Page 32)

By the time of the investigation in 2013, there had been positive change in both the management and operation of the CMHT.

“The CMHT has undergone change both in terms of management and structure. Staff we interviewed told us that improvements had been made following the trust’s internal review. They attributed this largely to the dedicated work of the team and its management in recent months.” (Mr G report page 55).

Managers and clinical staff within the CMHT feel that providing a service in Thanet posed particular problems. We met the assistant director of trust services in East Kent. He described the different cultures across the various parts of the large trust. He told us that:

“There is still a very different culture but I suppose Medway is an identifiable cultural block and West Kent and East Kent are still identifiable cultural blocks”.

He went on to say:

“You are dealing with a difficult environment that other people in other parts of Kent may not understand. Unemployment averages across Kent between three percent and four percent; Thanet 13 percent. It’s the drugs, the safeguarding issues you’re dealing with, the child protection issues, so there is a considerable difference”.

A participant in the focus group for this investigation told us that it “takes a certain kind of person to work in Thanet”. She told us that you have to be “robust” to work there.

Despite cultural differences across the trust, assistant director 1 felt that services in Thanet were genuinely improving and had been for some time.

Service manager 1, manager at Thanet, told us about several developments in the Thanet community mental health services since the incident in 2011. The most

recent of these was the introduction of PODs¹. GPs are attached to PODs based on location and there are two consultants in each POD along with a number of Thanet staff.

PODs have been operational in Thanet for about six months. Within Thanet there are three PODs plus an extra POD for recovery, Horizon² and duty. The staff at the focus group told us that they believe that PODs ensure that a service user's journey is more consistent. Service manager 1 told us:

“There have been so many changes in Thanet, because before I left we had also divided the teams into PODs, so each POD was managed by a senior... The PODs were GP-aligned, so we had five consultants and they had a group of GPs and we put in a social worker and a nurse. They had three people in each POD and seniors aligned with the consultants”.

Service manager 1 told us that they now have a new duty team³ which is made up of two nurses, a healthcare assistant and an admin worker. She said that:

“Every morning they had a screening session, so at quarter past nine there would be a screening where the senior for that day, because there was a rota, the senior would go in with the screening and then the consultants. Because there were five, each consultant had a day of the week where they would go into screening... so every morning there would be a screening meeting with the duty team, a consultant, a senior and a psychologist, if they were available”.

She went on to tell us how successful the introduction of the duty team has been:

“We were the first team to develop a duties team and we were the first team to go into PODs, we were the first team to do that... We talked about what we had done in the first few months of the merged team, we had the dedicated duty service – we had created that because there had not been anything like that and then it was nice because all the other service localities followed, so Thanet was the first one that had this dedicated duties team, which was really an excellent team”.

Senior trust staff told us that since the incident the trust has also:

- taken steps to ensure that staff prioritise the completion of RiO notes as soon after a meeting with a client as possible;
- given depot clinic staff access to client records so that they can update records immediately; and

¹ ‘PODs’ is the name given by the trust to teams of multi-disciplinary staff working with patients grouped according to their GP surgery.

² The Horizon Project, engages hard-to-reach young people and moves them towards independence through the provision of vocational training.

³ The remit of the duty team is to manage referrals, emergencies and any unscheduled or unclear calls/requests.

- introduced policies to support the care delivered in a depot clinic – these consist of the intra muscular injection procedure and the intimate care policy.

Evidence to support the improvements outlined above was provided by the trust and is reviewed in the action plan table in section seven.

Despite considerable improvements to Thanet services, it was evident during our focus group with staff and interviews with senior managers that there is still some way to go to ensure that changes to the service are fully embedded. We heard that although there has been a reduction in the number of cases that are left unallocated, caseloads remain high (70 in some instances) for each staff member. This obviously carries risks in terms of care coordinators being able to manage high caseloads effectively.

A staff member commented that many high-risk patients who would previously have been in hospital are now being managed in the community. This is of particular concern given the high caseloads.

We also found that there was a management restructure taking place. Since 2011 there have been a number of different managers at all levels within the service. The last change was in 2013 when the investigation into the care of Mr G was conducted. We found the present restructuring was due to the managers who implemented the changes in 2013 moving on to other roles.

Staff told us that the admin team works very hard to support them but that there is a delay in letters going to the GPs – there is currently a backlog of about 150 letters. Staff have taken to sending appointment letters themselves because otherwise they are received by patients after the stated appointment date.

One member of staff told us during the focus group that the trust has good systems in place now but needs to work on staff morale.

Another member of staff told us that RiO can still not be accessed in certain trust locations. Even when it can be accessed it is liable to crash and cause staff to lose assessments that have taken a considerable time to complete.

In consideration of these issues, it is our view that further work needs to be undertaken to ensure the community service is operating safely.

7. The internal review

The terms of reference for this investigation include assessing the quality of the internal investigation and review conducted by the trust.

In this section we examine the national guidance and the trust's incident policy to consider if the trust's investigation into the care and treatment of Mr D met the requirements set out in these policies.

7.1 Detection of incident

The trust became aware of the incident because a court liaison nurse, alerted nurse 1 of the community mental health team on 7 March. A managers' SI report was subsequently carried out.

7.2 The trust's SI review

The good practice guidance, Independent Investigation of Serious Patient Safety Incidents in Mental Health Services (NPSA February 2008), advises that, after a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and further action needed.

The trust introduced the Investigation of Serious Untoward Incidents, Incidents, Complaints and Claims policy in October 2009. This policy was still in place at the time of this incident, and was due for review in October 2011.

The trust's policy states that:

"... incidents occur across the trust and it is our responsibility to ensure that we can learn from these, avoid repeating the same mistakes and introduce safer ways of working, better services to patients and ensure high standards of care are delivered across the organisation".

7.3 Investigation process

The trust's Investigation of Serious Untoward Incidents, Incidents, Complaints and Claims policy, October 2009 states that:

"All Level 4 and 5 Incidents (red) will be subject to an Immediate Management Investigation and a further RCA [root cause analysis] investigation".

The policy also states:

"It is considered good practice for the RCA investigation to be undertaken by more than one person that enables greater objectivity".

The policy states that the investigation lead or team:

“May be drawn from local manager/senior manager responsible for the service or a local manager/senior manager from another part of the Trust and supported by other clinical and non-clinical staff. The appointment of the investigating lead will be made by the Service Director and the SUI Core Team.

“An investigation should be commenced within three days of the appointment of the Investigating Lead... the investigation should be concluded within 25 days/or an agreed date with the SUI Core Team... the report arising from the Investigation must be prepared and submitted within one week of the conclusion of the investigation”.

The terms of reference for the internal review were to consider:

“The care and treatment of... [Mr D] with specific attention paid to but not restricted to:

- Depot Clinics – the remit and role of the clinic for those attending
- The pathway of 'flagging' concerns to care Co-Ordinators following clinics

The investigators will use information already gathered by the Managers SI report and will consider the recommendations of other SI's Clinical SI Learning reviews – and where appropriate any independent recommendations.”

The trust's policy provides guidance for conducting interviews. It states:

“At all stages sensitivity and tact will be practiced with appropriate support available for anyone providing information... all those identified will be informed by letter, including the purpose of the investigation”.

The review team consisted of an access service manager and a quality assurance manager. It does not appear that they accessed any medical input for their review. As part of the review process they:

- built on information already gathered by the managers' SI report;
- considered Mr D's paper records and ePEX notes; and
- carried out three interviews (with the service manager, a CPN and a senior practitioner).

7.4 Submission and commissioning of the report

The first draft of the report was dated 25 July 2011; however, interviews did not take place until 4 and 12 August, therefore it is unlikely that that was a completed draft. Other drafts are dated 13 and 16 August with a final report dated December 2011. It

is not clear from the report when it was commissioned but it was submitted over five months after the trust became aware of the incident.

7.5 Findings and recommendations from the trust's review

The trust's management clinical learning review concluded:

“Having reviewed the notes and interviewed the staff we conclude that nothing could have been done differently to predict or prevent this incident happening. There was no evidence that this incident was as a result of Mr D's mental health problems. He was compliant with medication. On his last contact with the team and when he was subsequently assessed by mental health staff after the incident it was clear that he was not mentally unwell at the time. Although there were several issues raised from the investigation these do not appear to have any bearing on the outcome of the incident. There is clear evidence that the Service Manager, who had only been in post for 2–3 weeks prior to this incident, has put some positive measures in place to support the team in managing the workload with the support of senior management. This has been seen as a positive by the team although there were some comments about promises being made but not delivered on”.

We agree with the findings of the trust's management clinical SI learning review but would go further and say that (in line with our findings above):

- Mr D should have been managed under CPA and been clear about who his care coordinator was;
- a risk assessment should have taken place after Mr D moved to Moncrieff House with a clear crisis and contingency plan drawn up;
- depot staff should have been aware that they were the main/only contact Mr D had with mental health services and therefore his engagement with them should have been therapeutic; and
- more consideration should have been given to moving Mr D from supported to unsupported accommodation. If he was considered suitable to be moved to unsupported accommodation then monitoring arrangements should have been in place to ensure the move was and continued to be successful.

The trust's review made six recommendations:

1. Review the Recovery Service caseload.
2. Issue trust-wide guidance for depot clinics to ensure consistency across the organisation.
3. Continue to work with Moncrieff House (to identify possible safeguarding issues).
4. Risk assessments and CPA reviews should be held as a matter of course, when major changes happen to an individual, e.g. change of accommodation.
5. Team support following incidents.
6. For the team to be informed of any changes proposed and given the opportunity to contribute.

An action plan was compiled on 5 October 2011 and updated on 14 February 2012. The trust provided us with evidence to show that they had completed each of the action points (our comments on the evidence provided are documented in the final column of each point in the action plan).

Action Plan

Patient Initials:	Mr D	Trust SI Reference:	
Manager Completing Action Plan:	Debbie Weatherall/Andy Oldfield	Team/Ward:	The Beacon – Recovery Service
Directorate:	Eastern & Coastal <input checked="" type="checkbox"/> West Kent <input type="checkbox"/> Medway <input type="checkbox"/> Forensics <input type="checkbox"/>		
Person responsible for monitoring/review:	Debbie Weatherall	Date of Incident:	OVER WEEKEND 5 TH 6 TH MARCH 2011
Date Action Plan Created:	Combined SI and RCA Action plan created on 5/10/11, updated 14.02.12 RCA recommendations in blue	Brief Summary of Incident:	Homicide – Client Mr D assaulted a fellow resident at Moncrieff House – who later died.
Action Plan as a result of: SI <input type="checkbox"/> RCA <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> Complaint <input type="checkbox"/> Claim <input type="checkbox"/> Other <input type="checkbox"/>			

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
1	To review the Recovery Service caseload.	To identify those clients who are open to Recovery just because they are on a depot.	Debbie Weatherall Sharon Hassan (SP)	Sept 11 Nov 11	Completed. We are now in the process of setting up a review team so	We note that TS (senior practitioner) completed a paper on 8 December 2011. The paper sets out the positives and negatives

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
					<p>that these clients can be managed more consistently.</p> <p>Senior ■ to carry out Discharge clinic during September/October.</p> <p>■ has already identified clients who can be transferred back to GP for depot administration.</p> <p>Reviewed 04/12/11</p> <ul style="list-style-type: none"> • Review Team and Discharge Clinics now in place 	<p>of transferring service users back to primary care when they are settled on depot injections.</p> <p>■ also sets out some of the steps she has taken as part of the review of the recovery service caseload:</p> <ul style="list-style-type: none"> • Met with several GPs and practice nurses between October and November 2011 to discuss the complexities of discharging clients back to them and how we can work together on this. • Several reviews have taken place with Recovery and the recovery pool (OT). This has resulted in discharges and is ongoing. • The team's caseload has been reviewed and I have a copy of each care coordinator's case load. I will be shuffling the caseloads to ensure

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
						<p>fairness and balance.</p> <ul style="list-style-type: none"> • Myself and [REDACTED] (Senior Practitioner) have recently identified approximately 60 clients who have not had contact with the service in the past six months. Admin are in the process of drafting a letter to these clients asking whether they still require a service from us. <p>Update 15.02.12:</p>
2	<p>Trust-wide guidance for depot clinics to ensure consistency across the organisation</p> <p>If Depot Clinics continue there should be provision for staff to follow</p>	<p>Trust Depot Clinic Policy to be adhered to at all times.</p> <p>For staff working in Depot clinics to be provided with the necessary IT</p>	<p>[REDACTED]</p> <p>Recovery Team Senior Practitioners</p> <p>Recovery Service Manager</p>		<p>Reviewed 04/12/11</p> <ul style="list-style-type: none"> • A Trust Depot Clinic Policy is being drafted by the Clinical Nurse Lead for the CRSL. When ratified will be embedded into Recovery Team. <p>Reviewed 04/12/11</p> <ul style="list-style-type: none"> • For Depot clinics held at the 	<p>The trust provided us with a copy of the draft policy "Use of Intra Muscular Injection Medication in Community Mental Health Centre Clinics".</p> <p>We do not know whether the policy has been embedded and whether audits are taking place to ensure compliance.</p> <p>The trust provided a copy of the: DIRECTORATE OF</p>

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
	<p>the record-keeping policy by inputting their records fully and comprehensively. This may include laptops and VPNs</p> <p>Record-keeping regarding any client discussion must be adhered to – this should be audited</p>	<p>equipment.</p> <p>Trust Record-keeping Policy and Supervision Policy to be adhered to with all staff at all times.</p>	<p>Director IMT</p> <p>Service Manager</p> <p>Senior Practitioners</p>	<p>Nov 2011</p> <p>November 2011</p>	<p>Beacon there is now access to computers for staff to be able to update clinical records immediately.</p> <ul style="list-style-type: none"> Clinics held elsewhere still require staff to travel back to the Beacon to access clinical records <p>Reviewed 04/12/11</p> <ul style="list-style-type: none"> All staff now receive regular supervision where record-keeping is discussed 	<p>MENTAL HEALTH, EASTERN AND COASTAL Minutes of the Recovery Team Meeting, 13 December 2011. The minutes show that discussions have taken place to ensure staff have access to RiO at the Beacon – this has included considering using laptops. There is no information about whether an audit has taken place to ensure staff are routinely updating client records from the Beacon.</p> <p>The trust provided a copy of the trust-wide managerial and clinical supervision policy for all clinical staff working in clinical settings. Section 22 of the policy covers expectations around record keeping. It states: “Compliance with this policy and these legal and best practice requirements will be evidenced through</p>

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
	To discuss the Mr D case re accommodation with care coordinator.	Care coordinator currently off long-term sick	Tracy Simmonds (SP)		<p>Reviewed 04/12/11</p> <ul style="list-style-type: none"> Care Coordinator has recently returned to work. Supervision session due on 09/12/11 where this issue will be covered. 	<p>information into the electronic record, RiO".</p> <p>The trust also provided a copy of the supervision tree for Thanet.</p> <p>The trust provided a copy of the supervision session where case note audit was discussed.</p>
3	To continue to work with Moncrieff House	To identify possible safeguarding issues	[REDACTED]	December 2011	<p>Meeting attended by [REDACTED] in May 11. Meeting discussed afterwards with [REDACTED].</p> <p>Reviewed 04/12/11</p> <p>COMPLETED.</p>	<p>The trust provided an agenda for the Vulnerable Adults and HMO Accommodation meeting that took place on 24 May. Two agenda items were recorded as:</p> <ol style="list-style-type: none"> 1. Confidential Case presentation/discussion - Moncrieff House 2. Implications of case

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
						study, issues for follow up We have not seen minutes from this meeting to review actions agreed.
4	Risk assessments and CPA reviews should be held as a matter of course, when major changes happen to an individual, e.g. change of accommodation	<ul style="list-style-type: none"> Regular case note audits 'Lock down' time to update RiO Case note audits in supervision CPA training <p>CPA policy and Record Keeping Rules emailed to all staff on 7/9/11</p>		December 2011	A case note audit was carried out 2 – 9 th September 2011.	<p>DW sent an email to her team on 13 September 2011 saying:</p> <p>“I would like to book each of you in for individual supervision next week. Following the results of the recent audit, I will need to carry out case note audits with you at each supervision session from now on”.</p> <p>An email from  to her team on 2 September states:</p> <p>“Please as a matter of urgency, can all Care Coordinators;</p> <ul style="list-style-type: none"> Review their list of clients and ensure that they are all open on RiO.

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
						<ul style="list-style-type: none"> • They all have up-to-date CPA documentation • A recent Risk Assessment • That the DNA policy has been followed in the event of a client missing appointments and that this is recorded on RiO". <p>The trust also provided CPA training records.</p>
5	Team support following incidents.	To ensure that teams receive support and debriefs following all future incidents.	[REDACTED]	December 2011	Support was given to the care coordinator after this incident by senior practitioner [REDACTED] and the incident was discussed at the team meeting (acknowledged in RCA report).	The trust provided a copy of the SI report – this documented the support provided to staff following the incident.

	Recommendation/ Requirement	Action Required	Owner	To be Achieved by (date)	Progress of Action	Verita's consideration on progress made against the recommendation and evidence provided
6	For the team to be informed of any changes proposed and given the opportunity to contribute	To provide opportunities for staff to contribute to changes and receive information	[REDACTED]	December 2011	<p>Seniors Away Day held in April 2011 – facilitated by [REDACTED]</p> <p>H and S workshop held on 27/9/11.</p> <p>Development Day planned for 21/10/11</p> <p>Seniors Meetings</p>	<p>The trust provided a copy of the DIRECTORATE OF MENTAL HEALTH, EASTERN AND COASTAL Minutes of the Senior Practitioners Meeting held on 5 August 2011 at the Beacon. The minutes show the conversation that took place regarding proposed changes to the service.</p> <p>The trust also submitted an email from [REDACTED] following the seniors meeting with actions agreed at the meeting. This included proposed changes to the service/governance arrangements.</p> <p>The trust provided a copy of the THANET PROJECT GROUP WORKPLAN – 25 November 2011. This document proposed changes to the service.</p>

8. Overall analysis and recommendations

There were several important aspects which could have changed the way trust services engaged with Mr D. Despite this, we found nothing to suggest that this incident was predictable or preventable. Despite there being no link between the incident and the care of Mr D, this investigation has identified serious failures in the practice of care and the trust's clinical management of Mr D. One of the purposes of these independent investigations is to identify learning that might apply across other parts of trust practice. We summarise our main findings as follows.

- Failure to be clear about the level of CPA that Mr D was subject to.
- Failure to ensure that Mr D had a care coordinator and that his care was managed safely.
- Effective system for allocating a care coordinator.
- Failures in risk assessments and compliance with assessments that were completed (such as Mr D's need for supported accommodation).
- Failure of trust senior managers to have a policy on depot clinics. Such a policy should be introduced so that depot injections may be administered effectively and integrated into individuals' care pathways.

We have reviewed the trust's action plan and interviewed senior staff. It is clear that progress has been made in some of the areas listed above. The failures in Mr D's care identify serious weaknesses in clinical practice. It also identified weaknesses in clinical management – for example the lack of a depot clinic policy and continuing high community caseloads.

We conclude that the commissioners should closely review the progress the senior managers are making in ensuring that they have put in place effective systems and processes that support good clinical practice and identify where weak practice is present.

8.1 Recommendations

R1 The trust should assure themselves and the CCG that clients are allocated to the level of CPA in accordance with the trust guidelines. This includes documenting who is responsible for coordination of care and how regularly reviews should be conducted.

R2 The trust should assure itself that the delivery of care and support to an individual complies with CPA guidelines (including care planning, risk assessment and risk management planning). The clinical governance team should audit compliance at least every six months and report its findings to the board.

R3 The trust has introduced guidance to govern the way in which depot clinics are managed. We recommend that the trust undertake an audit to ensure compliance with the new guidance.

R4 The trust should review the protocols with partnership agencies such as housing services to ensure effective communication and information-sharing for the safety of patients and the general public. This should take place within the next three months.

Team biographies

Amber Sargent

Amber joined Verita as a senior investigator in 2009. Previously she worked at the Care Quality Commission (CQC) where she led on several major investigations into patient safety, governance and concerns around performance. At Verita Amber has worked on a wide range of investigations and reviews, including those into the care and treatment of mental health patients convicted for homicide or murder. She specialises in patient safety systems and benchmarking.

Geoff Brennan

Geoff Brennan is a registered nurse for the mentally handicapped and a registered mental health nurse. Geoff has worked in a variety of clinical and academic posts, mainly in London and the southeast of England. Geoff has practised and taught psychosocial interventions for psychosis since the early 1990s. Geoff was chair of the standing nursing conference mental health group for London for five years.

Throughout his career Geoff has maintained an active involvement with acute care, including carrying out the benchmark of London Inpatient Services for the London Development Centre and for three years was one of two city nurses working in east London to improve acute inpatient wards. Since 2006 Geoff has worked as a nurse consultant in acute care both in Berkshire and now in Camden and Islington Mental Health Trust. Geoff has published numerous articles and research papers on acute mental health and also co-edited a major textbook for nurses. For two years Geoff has also been the national chair of the Consultant Nurse Association.

List of interviewees

Individual interviews held with:

- Nurse 1, community psychiatric nurse (CPN)
- Service manager 1
- Senior social worker practitioner 1
- Assistant director 1

Focus group attended by:

- Senior nurse practitioner 1
- Nurse 4, community psychiatric nurse
- Senior occupational therapy practitioner 1
- Senior nurse practitioner 2
- Social worker 2
- Nurse 1, community psychiatric nurse
- Thanet service manager 1, current Thanet service manager

Documents reviewed

Medical records

- Mr D's clinical notes

Policies and procedures

- Care programme approach policy, December 2007
- Management of incidents, including the management of serious untoward incidents, November 2008
- Care programme approach policy, July 2009
- Investigation of serious untoward incidents, incidents, complaints and claims, October 2009
- Trustwide management and clinical supervision policy for all clinical staff working in clinical settings, December 2009
- Care pathways policy (incorporating care programme approach), April 2010
- Health and social care records policy, July 2010
- Care pathways policy (incorporating care programme approach), December 2010
- Care programme approach policy, October 2012
- Clinical records policy, August 2013
- Use of intra muscular injection medication in community mental health centre clinics, October 2013

Internal report

- SI review report, August 2011
- SI action plan

Other

- Information on depot clinics
- Thanet recovery team supervision tree
- KMPT approved record of management/clinical supervision
- Minutes of recovery team meeting
- Emails regarding case note audits and record keeping
- Thanet project group workplan