

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

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

**Mr E**

A report for  
NHS England, North Region

August 2014

Authors:  
Kathryn Hyde-Bales  
Peter Jefferys

© Verita 2014

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

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

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

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

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

## Contents

1	Introduction	4
2	Terms of reference	6
3	Executive summary and recommendations	7

### Details of the investigation

4	Chronology of care and treatment	16
5	Analysis of themes	25
6	Mr E's diagnosis	26
7	Risk assessment and risk management	27
8	Care pathway	34
9	CPA and care coordination	36
10	Discharge planning / after care	38
11	Forensic services and MAPPA	40
12	Drug and substance misuse	42
13	Presentation on 30 January 2011	43
14	Predictability and preventability	45
15	The trust's internal investigation report	48
16	The trust's progress made against the internal investigation recommendations	51

### Appendices

Appendix A	Biographies	57
Appendix B	Trust internal investigation recommendations	58
Appendix C	Trust action plan	61
Appendix D	Documents reviewed	66

# **1 Introduction**

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

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr E, who killed Mr X on 30 January 2011.

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

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

## **1.2 Overview of the trust**

Pennine Care NHS Foundation Trust provides mental health and community services to people living in Oldham, Rochdale, Bury, Stockport, Glossop and Tameside. The trust also provides community services in Trafford.

## **1.3 Approach to the independent investigation**

NHS England, North Regional Team commissioned a type C independent investigation. This type of review does not seek to reinvestigate a case from the beginning. The independent investigation team builds upon any investigative work that has already been carried out by the trust.

The investigation team consisted of Kathryn Hyde-Bales, senior consultant/investigator and Dr Peter Jefferys, consultant psychiatrist. Dr Jefferys provided expert advice and undertook a review of Mr E's clinical records. Chris Brougham, senior consultant, peer reviewed the report. From now on the investigation team will be referred to as 'we'. Our biographies are in appendix A.

We reviewed documentary evidence. This included:

- national guidance;
- trust policies and procedures;
- Mr E's clinical records; and
- the trust internal investigation report.

We interviewed the following staff:

- service director for the North Division;
- lead for integrated governance – Mental Health Services; and
- chair of the internal investigation.

Mr E gave us permission to review his medical records. We met with Mr E to discuss his care and treatment. We sent him a copy of our report to comment on prior to publication.

We contacted the police to request copies of details of Mr E's forensic history, which they supplied. We contacted Mr E's GP surgery to discuss his medication.

We were not able to find contact details of Mr E's next of kin, and therefore no members of Mr E's family were involved in the investigation. Mr E's notes record "Father is unknown to [Mr E], mother had no contact for numerous years".

NHS England contacted the family of the victim to ask if they wished to be involved in the investigation. They declined, but asked that they be kept informed by NHS England of developments and that the findings be shared with them.

This independent investigation report includes a chronology outlining the care and treatment of Mr E. Analysis appears in sections 6 to 16, where particular issues and themes are highlighted.

## 2 Terms of reference

The terms of reference for the independent investigation into Mr E, set by NHS England, in consultation with Pennine Care NHS Foundation Trust are detailed below.

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

## **3 Executive summary and recommendations**

### **3.1 Introduction**

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

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

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

### **3.2 The incident**

Mr E attended a Salvation Army hostel shortly before 11pm on 30 January 2011. He talked to staff then left. Mr X, the victim, lived near the Salvation Army hostel. Mr X was a 67 year old gentleman who lived and worked all of his life in Rochdale. The family of Mr X told NHS England that he was a well-respected member of the community. On the night of the incident Mr X walked past the hostel. Mr E followed him and beat him in a sustained attack.

Mr E returned to the hostel at 11.05pm reporting that he had “killed [Mr X]”. He then struck and head-butted another resident. At 11:32pm another resident reported that there was a person (Mr X) on the ground in a pool of blood. The emergency services were contacted.

At 11.55pm the police went to Mr E’s house and arrested him. The police described Mr E as being “confused, delusional and making inappropriate comments”.

Mr X unfortunately died of his injuries on 31 January 2011.

Mr E was detained under Section 3 of the Mental Health Act (MHA) and transferred to a medium secure forensic mental health unit. He was charged with Mr X’s murder in June 2011.

Mr E pleaded guilty to manslaughter on the grounds of diminished responsibility at Manchester Crown Court on 14 November 2011. He was sentenced to a hospital order with restrictions and was returned to the medium secure unit.

### **3.3 Overview of care and treatment**

Mr E's GP referred him to mental health services at Pennine NHS Foundation Trust services in December 2007. Prior to this Mr E had been living in Ireland.

Mr E was diagnosed with schizophrenia. He had a history of violence and was known to abuse drugs and alcohol.

Mr E engaged with mental health services extensively and was under the care of the Assertive Outreach Team (AOT) until the offence in 2011. The level of his engagement with services was variable. He was detained under the MHA on a number of occasions.

In early 2008, Mr E was detained under section 2 of the MHA. In April 2008, he was arrested for a number of unprovoked assaults and was detained at Forest Bank prison. He was subsequently convicted of three offences and sentenced to four months' imprisonment.

Mr E was admitted to a mental health ward at Pennine NHS Foundation Trust on an informal basis on 24 February 2009. He was noted to be carrying a weapon and had not been taking his medication. He was diagnosed with paranoid psychosis. Mr E was discharged to the AOT on 10 March 2009.

Mr E was again detained under Section 136 of the MHA on 22 March 2010. This was subsequently converted to Section 2 of the MHA. During this admission Mr E was granted periods of leave, the length of which was variable according to his behaviour. While on the ward there were incidents recorded in the notes in which he described as aggressive and threatening to staff and patients. He went absent without leave (AWOL) on more than one occasion. He remained an inpatient until his discharge to the AOT on 12 May 2010.

Mr E was admitted to a mental health ward on an informal basis on 10 September 2010. During his admission he was granted periods of leave. He was discharged to the AOT on 22 October 2010.

Mr E was arrested on 20 January 2011 on suspicion of burglary and criminal damage. The police surgeon believed that Mr E warranted psychiatric assessment. Mr E had indicated that he was willing to be admitted informally. He was subsequently assessed by a consultant psychiatrist who concluded that Mr E did not need to be sectioned under the MHA. Mr E was released without charge and no further action was taken. The AOT visited him on 23 and 24 January but he was not at home.

Mr E went to A&E on 25 January 2011. He reported that he had kicked a wall and was experiencing pain in his knee. He was treated and discharged.

Mr E's care coordinator assessed Mr E on Friday 28 January. The care coordinator noted that Mr E appeared delusional and had stopped taking his medication, though

Mr E denied any thoughts of actual harm. The care coordinator contacted Dr3<sup>1</sup> (who had undertaken Mr E's mental health assessment on 20 January at the police station). Dr3 said that he would see Mr E the following week.

Mr E was seen by chance on 29 January by a member of the Community Mental Health Team (CMHT) during the assessment of another patient. It was reported that Mr E was acting in a bizarre and intimidating manner.

Mr E attended the Salvation Army hostel after 8am on 30 January with a serious hand injury. Staff advised him to go to A&E, which he subsequently did but he was not booked in. He was reportedly "loud and demanding" and left without receiving treatment.

At 9.10am Mr E was seen walking down the road by a student nurse who knew him. The student nurse reported that Mr E was acting strangely and had blood on his clothes. The student nurse contacted the police.

The police attended Mr E's home at 9.22am on 30 January. They forced entry into his home and subsequently accompanied the ambulance that was called to take him to hospital. The treating doctor noted that Mr E was under the care of [mental health services] psychiatry. Mr E received treatment for his injured hand in A&E and was then discharged.

This was the last time that Mr E was seen by health services before he committed the offence.

### **3.4 Overall conclusions of the investigation**

Mr E was allocated to the AOT caseload in March 2008 and remained under its care until the offence in January 2011. The exceptions to this were when he was an inpatient. We have focused primarily on the 12 months preceding the incident in January 2011.

Mr E was predominantly managed by his care coordinator but was well known to the team in general. Mr E could be difficult for the team to manage. Difficulties included:

- unpredictable violence and aggression;
- abuse of drugs and alcohol;
- refusal to engage;
- non-compliance with treatment; and
- periods of unscheduled absence.

#### **3.4.1 Diagnosis**

We have considered Mr E's diagnosis. The written record demonstrates strong evidence to support his long-term diagnosis of schizophrenia.

---

<sup>1</sup> Dr1 and Dr2 are referred to in the main body of the report but are not referred to in the executive summary.

## Finding

Mr E's diagnosis of schizophrenia was appropriate.

### 3.4.2 Risk assessment and risk management

Mr E's risk assessments clearly documented his propensity towards violence, his anger issues and that he was known to carry weapons. On 22 October 2010 a risk assessment was conducted on the ward. It was recorded that Mr E said he wanted to harm someone, although he did not explicitly name an individual. The ward round notes for the same day recorded that he was not delusional and showed no signs of psychosis. He was discharged from hospital on 22 October 2010.

After Mr E's discharge from hospital he returned to the care of the AOT. There is no record that a subsequent risk assessment was undertaken from that point onwards up until the incident in January 2011.

Mr E had agreed to being admitted to hospital on a voluntary basis on occasions in the past. In particular, in September 2010, Mr E's care coordinator acted appropriately, taking steps to have Mr E admitted as a means of preventing harm to the public. During that admission, risk assessments were repeated and adjustments made to Mr E's medication and leave in response to changes in the perceived level of risk. However, apart from physical containment in hospital as a means of reducing risk of harm to others, Mr E's management plan during his two admissions in 2010 failed to address many of the contributory features linked with his risk of violence. For example, although he was given oral antipsychotic medication on the ward, there is no evidence that a management plan was devised to address his repeated non-compliance in the community. Similarly there is no evidence (apart from inpatient admissions) that the recurrent and serious problem of Mr E's substance misuse was included in his community management plan. Mr E showed sexually inappropriate and manipulative behaviours while in hospital. These behaviours were considered by those managing him to be significant risk factors but they were not addressed as part of his clinical risk management plan before his discharge.

There is no indication that a structured risk assessment was used in the formulation of Mr E's community management plan. There was not a care plan in place that explicitly addressed his risk of violence. This should have been provided in compliance with the trust care programme approach (CPA) requirements.

## Findings

There is no evidence that Mr E was subject to a systematic risk assessment after his discharge from hospital in October 2010.

Clinicians working with Mr E did not have access to an effective written risk management plan that reflected his risk assessment.

On his discharge from hospital, Mr E did not have an appropriate and explicit risk management plan for his community management in October 2010. This was a serious omission.

#### Comment

These shortcomings represent a serious oversight, not only because Mr E's risk profile was unknown, but because his effective community risk management depended on reliable up-to-date information, which should have been part of his risk management and discharge from hospital.

#### 3.4.3 Pathway of care and care planning

Mr E's care pathway was not effective and did not comprehensively explore alternative care options. We found no indication that serious consideration was given in 2009 or 2010 to the use of long-acting injectable antipsychotic medication. We acknowledge that it is unlikely that Mr E would have agreed to this course of treatment, and that its enforcement would have required his detention or the application of a community treatment order (CTO)<sup>1</sup>, which must be preceded by a period of detention. We found no record of any professional discussion of the use of a CTO as part of Mr E's community management in 2010. We note that it is by no means certain that a CTO would have been agreed on and implemented, but it was a serious omission not to explore the option.

After discharge in 2010, Mr E's care plan appeared to focus primarily on maintaining contact with him on a semi-regular basis to provide low-level monitoring of his mental state and to assist him with tasks such as the care of his cats. As a care plan, this was of little assistance in informing an appropriate professional response to developments in January 2011.

Mr E was subject to what we consider a "light touch" care plan. This was in spite of the historic risks that were known to the AOT. The internal investigation highlighted that clinical and management supervision of the care during this period was not effective.

#### Finding

Mr E's care pathway did not comprehensively explore alternative care options for him and was not effective.

#### Comment

The lack of an effective care plan for Mr E hindered an appropriate professional response to developments in 2011.

---

<sup>1</sup> A Community Treatment Order is the process by which patients sectioned under the MHA are given supervised treatment in the community. Failure to adhere to the conditions of treatment may result in the patient being recalled to hospital.

#### 3.4.4 CPA and care coordination

Mr E met the trust's criteria for CPA and he had a care coordinator. We note that Mr E's care coordinator had found it increasingly difficult to manage him and by his own admission, was at serious risk of "burn out". Steps were taken to replace him. However, Mr E did not agree with this plan and he was returned to the original AOT worker's caseload. We do not deem this to have been an adequate response to addressing the long-term difficulties that the member of staff was experiencing. Mr E's care coordinator told the trust internal investigation that he felt that the team as a whole was essentially monitoring Mr E rather than progressing with his recovery.

Mr E's last CPA review took place on 22 October 2010, the day he was discharged from hospital. There was not another CPA review despite indications that his behaviour in the community was deteriorating.

#### Finding

We found no evidence of a robust multi-professional review, such as a CPA review meeting, after Mr E was discharged from hospital in October 2010.

#### 3.4.5 Discharge planning/after care

The threshold for Mr E's discharge was fairly low in 2010, as shown in October when he was discharged days after exhibiting significant paranoid and psychotic symptoms, which included threats towards others. The trust internal investigation report makes the valid observation that Mr E's unpleasant and at times abusive and threatening behaviour towards staff created an atmosphere in which there was pressure to discharge him. When Mr E pressed for discharge in October 2010 the alternative options were limited. Mr E could either be discharged and followed up by the AOT, as happened, or be detained under the MHA with a view to exploring other long-term options.

#### Findings

The threshold to discharge Mr E from hospital in May and October 2010 was lower than a realistic risk assessment would indicate.

The AOT took active steps to engage with Mr E after his discharges from hospital in May and October 2010.

#### 3.4.6 Forensic services and MAPPAs

The AOT did not believe it necessary to refer Mr E to forensic services for assessment after his referral to the Mentally Disordered Offenders (MDO) team in March 2010. In light of the seriousness of Mr E's known risk of violence to others, the failure to press for forensic services advice on the management of his risk in a community setting was an omission. We note, however, that the absence of further criminal charges against Mr E was seen by the MDO team as an obstacle to further

engagement. The trust internal report noted that in light of the criteria for Multi Agency Public Protection Arrangements (MAPPA) referral operating locally at the time, such a referral would have been unlikely to have provided much assistance in this case.

### Findings

The AOT did not refer Mr E to forensic services for assessment or seek their advice on management.

Mr E was referred to the MDO team in 2008 and 2010. On neither occasion was he accepted into the team's caseload as he did not meet their referral criteria.

### Comment

It would have been helpful for the AOT to have sought advice from the forensic service in relation to managing Mr E, whose presentation was complicated by a combination of relapsing psychotic illness, drug misuse, offences of violence and personality difficulties.

#### 3.4.7 Drug and substance misuse

Mr E's substance misuse was a problem recognised by the trust throughout his care. It was known that he abused – although he was not addicted to – a range of illicit drugs which usually had an adverse effect on his mental state.

Inpatient services had the opportunity to seek advice from the drug and substance misuse service during Mr E's admissions in 2009 and 2010. Mr E may have been more accessible when in hospital, and suggestions could have been made to assist subsequent AOT community management.

### Comment

Inpatient services did have the opportunity to engage with the drug and substance misuse service, however in the circumstances, given Mr E's repeated unwillingness to address these issues, the trust cannot be reasonably criticised for failing to liaise with the service.

#### 3.4.8 Presentation on 30 January 2011

We have considered the events of 30 January as a whole from the point of Mr E attending the Salvation Army hostel in the morning until his return late at night the same day. When Mr E attended A&E there is no indication in the notes that staff had concerns about his mental state in the short time that he was there. There was no obvious need for A&E staff to seek immediate mental health advice.

We have no criticism of the A&E staff. The exception to this would be if A&E staff had been given information about Mr E's risk either previously by mental health

services or by police officers escorting him that day. We found no evidence to indicate that this had happened.

#### Finding

A&E staff acted appropriately on 30 January 2011.

### **3.5 Predictability and preventability**

In reaching a conclusion about predictability and preventability we set out below the standards against which we have assessed Mr E's care.

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

We consider that the homicide would have been preventable if the professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

We have considered the circumstances, information and means available to the AOT about Mr E at the time of the incident in January 2011 and conclude that the team could not have predicted the incident nor was it in a position to have prevented it.

#### 3.5.1 Findings

We find that, while it could have been predicted that Mr E would be violent, the extent to which his violence would escalate could not have been foreseen.

We find that the death of Mr X could not have been prevented.

### **3.6 The trust internal investigation report**

The trust undertook a comprehensive internal investigation that addressed the terms of reference, provided evidence-based findings and made clear recommendations in relation to improving practice.

#### 3.6.1 Finding

The trust internal investigation fulfilled the terms of reference, was comprehensive and in line with trust policy.

### **3.7 The trust's progress made against the internal investigation**

#### **recommendations**

The trust has significantly overhauled mental health services since 2010, and has a strategic plan, changes for which are scheduled to continue into 2015. We accept that progress with the action plan runs in parallel with the restructure, and that consequently there are areas that the trust needs to work on. We were not given evidence of progress against all the action plan recommendations, rather we were told of what was planned. As a result in turn, we recommend that progress against the action plan be reviewed again at a later stage once the new service structure is further embedded.

#### **3.7.1 Finding**

The trust's progress against the action plan is continuous and scheduled for completion in March 2015.

### **3.8 Recommendations**

There has been a significant overhaul of mental health services at the trust since 2010 and changes are continuous. The AOT no longer exists and the service transformation is scheduled for completion in March 2015. As a result of this we anticipate that it will take time before the new model and ways of working are fully embedded at the trust.

We recommend that the trust's progress against the action plan be audited within 12 months and used to examine the extent to which changes are effectively embedded within the trust's structure and mental health services.

## **4 Chronology of care and treatment**

### **4.1 Background**

Mr E was born in London on 31 December 1969 and raised in Ireland. He was cared for by his mother until the age of 10 years, and then by his stepfather. He had had a number of episodes in mental health services and in prison in Ireland. In 2006 he moved to Longsight, Manchester but returned to Ireland because he was homesick. Mr E returned to England in 2007 and began living in Rochdale, where he was initially homeless. He was 41 years old at the time of the incident.

### **4.2 1998 – 2006**

Mr E first engaged with mental health services in 1998 when he was admitted on an informal basis to hospital in Ireland. He presented with grandiose and persecutory delusions. On admission he tested positive for cannabis.

In June 2000 Mr E was admitted to the Central Mental Hospital, Dublin, Ireland.

He was diagnosed as having drug-induced psychosis and a dissocial personality disorder. He failed to attend a follow-up appointment.

Mr E was admitted to hospital via the police in January 2004 for “delusional drug induced psychoses”. He was subsequently discharged to prison.

In January 2006 Mr E kicked someone in the head and was imprisoned for assault. At the time of his arrest he was considered to be mentally unstable. A few days after his imprisonment Mr E was reported to be elated and psychotic. He was later bailed but re-committed to prison following an unprovoked assault. He was experiencing delusions about the IRA and believed that a celebrity had been sexually assaulted.

### **4.3 2007**

On 19 June Mr E was deemed by medical professionals to be a serious priority risk to the public and had assaulted a tourist. He was arrested for threatening behaviour and assault. He displayed disordered thinking and was transferred from prison to hospital. He presented with persecutory ideas and was assessed to be elated, irritable and grandiose with a history of substance misuse. Mr E moved to England after this admission.

Mr E was first referred to Pennine Care NHS Foundation Trust by his GP on 3 December 2007. In the referral the GP noted that Mr E had recently arrived from Ireland and been diagnosed as schizophrenic. Mr E was prescribed olanzapine (an antipsychotic). An outpatient appointment was arranged for 24 January 2008.

Mr E was arrested in December for assault and reportedly given a caution.

#### 4.4 2008

Mr E was unable to attend the outpatient appointment arranged for 24 January 2008 because on 13 January he was admitted to Birch Hill hospital under Section 2 of the MHA. Records show that Mr E was extremely threatening in manner, expressing racist abuse, and sexually disinhibited. He was assessed as experiencing a psychotic episode and found to be using cannabis and cocaine. He quickly settled and disclosed that he had an extensive forensic history in Ireland and had been in prison for lengthy sentences.

Mr E was placed in seclusion on 14 January due to being a high risk to others. During his admission Mr E was referred to the psychiatric intensive care unit (PICU). After a delay he was accepted by the PICU however ward staff felt that they could continue to manage Mr E on the ward.

On 30 January the CMHT asked for Mr E's discharge to be delayed while a care coordinator and discharge care plan could be put in place. A member of staff from the MDO team attended the ward round. The delay and rationale for not discharging Mr E were documented.

Mr E was discharged from Birch Hill hospital on 7 February and was prescribed risperidone (an antipsychotic).

Mr E was arrested for assault on 11 March. An emergency mental health assessment was undertaken at the police station. He was assessed to be deluded and was admitted under section 2 of the MHA. During his admission Mr E was aggressive and abusive. He was discharged early from the Section 2 (an appeal had been lodged). Poor compliance with medication was noted as a cause of relapse. Ward reports indicated that Mr E was pleasant and compliant with treatment.

Mr E was arrested on 16 April after a number of unprovoked attacks on the public in Rochdale. A mental health assessment took place the next day at the police station. Mr E was assessed as not detainable under the MHA and was therefore transferred to Forest Bank prison.

A psychiatrist from Forest Bank prison wrote to adult services and the consultant psychiatrists at the Edenfield Centre and Birch Hill hospital on 2 June to say that Mr E was responding to treatment.

On 27 July Mr E was convicted of three offences of public disorder against the person and against property. He was sentenced to four months' imprisonment. In prison Mr E was assessed by the forensic psychiatric services, which had obtained information from the Irish psychiatric services. There was sufficient concern over Mr E's risk profile that the forensic psychiatric service recommended that he be transferred to a medium secure unit for further assessment. However, Mr E was released from custody before a transfer could take place as the authorities took account of time in prison on remand. The forensic service contacted mental health services in Rochdale to relay its concerns about Mr E's risk profile and give advice on how he should be managed.

#### **4.5 2009**

Mr E was seen at home by the AOT on 14 January. He presented with mild symptoms of psychosis and asked for benzodiazepines (a class of psychoactive drugs used to treat anxiety, insomnia, and a range of other conditions). He was already prescribed olanzapine and was commenced on escitalopram (an antidepressant) for panic symptoms.

On 24 February Mr E was admitted on an informal basis to Hollingworth ward at Birch Hill Hospital. He was found to be carrying a knife and had been non-compliant with medication. He was diagnosed with paranoid psychosis.

Mr E settled on the ward and was discharged on 10 March with planned follow-up from the AOT. His dose of olanzapine was increased to 20mg at night. He was also prescribed zopiclone (used to overcome sleeping difficulty) and clonazepam (used to treat seizures and panic disorders).

The AOT saw Mr E on 23 October for his CPA review. The team referred Mr E to the crisis resolution/home treatment team (CRHTT) because his mental state had deteriorated and the AOT team could not monitor him out of hours. He had admitted taking illicit substances which had heightened his arousal and led to auditory and visual hallucinations. He described it as a "bad trip". Mr E reluctantly agreed to engage with the CRHTT. Mr E was referred back to the AOT on 26 October after the crisis had passed.

#### **4.6 2010**

On 22 March Mr E was admitted to Birch Hill hospital under section 2 of the MHA, having been detained earlier by police under s136. He was experiencing psychosis and had been using skunk (a type of cannabis), crack and alcohol. He had been arrested the day before by police over allegations that on 20 March he had assaulted a young girl and had been racially abusive and sexually disinhibited. Mr E was put under section 3 of the MHA on 24 March.

On 27 March Mr E threatened to harm another patient and made racist comments to a member of staff.

On 1 April the husband of a patient complained that Mr E had given his wife cannabis and had been making inappropriate sexual advances. Mr E was found to be under the influence of substances and was threatening to staff. He was subsequently reported as extremely threatening and abusive to staff when he was refused permission to go outside.

Throughout April Mr E was aggressive and threatening to staff and patients. Planned leave with support by the AOT was cancelled due to his behaviour, which included smoking cannabis when on leave. He absconded from the ward three times during the month, usually for a few hours but once overnight.

Mr E's named nurse wrote a report on 19 April for his mental health review tribunal, scheduled to take place on 1 June<sup>1</sup>, recommending that Mr E remain on section 3 of the MHA due to his aggressive mental state and on-going statements that he wished to harm others.

On 21 April it was agreed that Mr E could start taking three hours unescorted leave and that he would be taken by AOT staff to visit his cats once a week. His leave was extended further on 28 April.

Dr1, an AOT consultant psychiatrist, wrote to the police on 30 April asking if there were any child protection issues that the AOT should be made aware of with a view to updating Mr E's historic and contemporary risk profile. It was reported at a ward round on 12 May that the police had confirmed they did not have a record of an assault on a minor.

Mr E was discharged from inpatient care on 12 May. Dr2, an ST2 (a doctor in the second year of specialist training in psychiatry) with the AOT, wrote to Mr E's GP the same day to advise that Mr E was no longer detained under the MHA, having been discharged by his consultant (under Section 23 of MHA). Dr2 noted that Mr E appeared "bright, calm [and] well kempt". It was added that Mr E had not expressed any thoughts of self-harm or abnormal thoughts. It was planned that Mr E's zopiclone would be stopped and his clonazepam tapered off in a community setting whilst being followed up by the AOT but he would remain on olanzapine.

Mr E was seen five days later by the AOT as part of the 'within seven-day follow-up' required by trust policy. His prescription was organised with his GP. Mr E reported that he felt "a bit down" but was pleasant.

A member of staff from the AOT attempted to contact Mr E on 3 and 7 June. On both occasions contact was not made. It was reported on 18 June that Mr E had made no contact. The AOT multidisciplinary team met and agreed a plan to keep him engaged.

Mr E was seen by chance on 30 June by AOT staff. He was reported as feeling "ok" and said that he was moving house and would make contact when he got a phone. An AOT visit was arranged and took place on 2 July. No concerns were noted.

The AOT tried to visit Mr E at home on 9 July but he did not respond. The team managed to contact him by phone on 12 July. He told the team that his GP had stopped his medication. The AOT was unable to contact the GP to discuss this. A home visit scheduled for 16 July was cancelled due to staff sickness/shortages.

A member of staff from the AOT saw Mr E on 23 July. He appeared well and had no symptoms or thoughts of harming others. He reported that he was happy to have stopped zopiclone and was now sleeping well.

Mr E was not seen again until 10 September despite a number of attempts being made by the AOT.

---

<sup>1</sup> Mr E was discharged from both section 3 and hospital in May before the tribunal took place.

Mr E contacted the service on 10 September saying he was unwell and requesting an admission. He refused to attend A&E and was subsequently assessed at home. It was reported that Mr E had made plans to kill his friends. The AOT undertook a risk assessment on 10 September in which it was recorded that Mr E was experiencing hallucinations and an increase in paranoia. Mr E described himself as a risk to others.

Mr E was admitted informally to Hollingworth ward. He was also thought to have taken an overdose. His speech was full of religious references. Mr E was reported as aggressive on the ward, particularly when his demands were not met. Mr E was prescribed clonazepam, zopiclone and olanzapine on the ward.

A clinical management review took place on 14 September. It was agreed that the AOT maintain contact with Mr E. The AOT saw Mr E on 17 September prior to his ward review. It was reported that he was still having violent thoughts about others.

The AOT contacted Mr E by telephone on 21 September. He wanted to visit his home to see his cat. Mr E went on leave on 24 September. When he returned ward staff suspected that he had been taking drugs.

Mr E was granted overnight leave on 1 October. It was envisaged that such leave would be permitted again, subject to daily review. Staff also encouraged Mr E to take leave during the day.

The trust internal investigation report said that Mr E was seen by the AOT during his leave on 13 October<sup>1</sup>. It was reported that he was feeling better.

It was alleged by a patient on 18 October that Mr E had slapped him in the face. The details of the incident were not clear. It was not witnessed and Mr E denied the allegation.

A meeting took place on 18 October during which Mr E's case was discussed by the consultant psychiatrist with the AOT also present. The trust internal investigation report said that "it was felt Mr E was improving; he had no psychosis and there were no reported threats to others". It was agreed that Mr E would be discharged from the ward with AOT follow-up.

It was recorded in Mr E's weekly review notes on 21 October "mood stable, no threats to others, compliant with meds, no psychosis currently evident [and] no delusional ideas expressed".

A risk assessment conducted on the ward on 22 October recorded that Mr E had expressed a wish to harm others and that he felt he was a dangerous person. His mental state was recorded as stable and it was noted that he had not expressed any delusional beliefs or evidence of psychosis. Mr E was discharged from the ward the same day.

---

<sup>1</sup> It was written in Mr E's ward notes on 13 October that the AOT had contacted the ward to say it was unable to see Mr E that day and had rearranged the meeting for the following Friday.

The AOT also saw Mr E on 22 October, to undertake a CPA review. This was completed as part of the multi-disciplinary team ward round when Mr E was discharged. It was attended by a consultant psychiatrist. Mr E was receiving olanzapine 20mg, zopiclone 7.5mg and clonazepam 1mg. Mr E was regarded as cooperative.

The AOT undertook a seven-day follow-up home visit on 27 October. Mr E was not home, so a contact card was left. The AOT visited the next day. Again, Mr E was not home and a card was left. On 29 October the AOT manager became involved because Mr E's seven-day follow-up had been breached. It appeared that Mr E was avoiding contact. It was agreed that the AOT would visit twice over two days and that the police should be told and asked to undertake a welfare check.

The AOT undertook the two visits to Mr E's home in early November but he was not seen. Further attempts to locate him were unsuccessful. It was reported by a neighbour that Mr E had been at home. A plan was made to contact Mr E on a daily basis. The police decided that there was no further action for them to take.

Mr E contacted the AOT on 4 November. He was seen by his care co-ordinator in Rochdale on the same day. He was assessed as not having psychotic symptoms. Mr E reported that he had been "bingeing on crack cocaine since his discharge". He was quoted as saying that he "intended to spend more time at home to address his gambling and substance misuse".

A member of the AOT spoke with Mr E on the phone on 8 November. Mr E said that he was well. He was seen four days later in Rochdale and given a crisis loan for his gambling debts. Mr E was noted to have mental capacity.

AOT staff visited Mr E at home on 16 November. Mr E presented as pleasant and well. The team tried to undertake another home visit on 24 November but Mr E was not in.

Mr E phoned the AOT on 2 December. He said he was "doing ok" but had on-going financial problems. AOT staff visited Mr E on 7 December but he was not home so a contact card was left. Mr E subsequently phoned the team and agreed to meet with them on 9 December.

Mr E was seen by AOT staff on 9 December. The notes say he denied that he was hearing voices and reported that he was avoiding gambling and cocaine. He agreed to meet them again in two weeks' time.

A member of AOT staff saw Mr E on 23 December. Mr E said that he was drug free. Mr E showed no signs of psychosis or thoughts to harm others. It was agreed that because he was stable he would be seen in three weeks but that he could contact the team if he needed any help or support.

## 4.7 2011

The trust internal investigation report stated that Mr E was seen by the AOT on 12 January. He presented well and voiced no thoughts of wishing to harm others. He said that he was drug free.

The duty approved mental health professional (AMHP) called the AOT on 20 January to report that Mr E had damaged a door and was in custody and needed psychiatric assessment. He had been arrested on suspicion of burglary and criminal damage.

Mr E said he was using crack cocaine (he tested positive) and asked to be admitted to hospital, reporting that he was hearing voices that told him to harm others. The police surgeon described Mr E as a risk to others. Dr3, a consultant psychiatrist, who already knew Mr E, undertook a MHA assessment.

Dr3 made a clinical record at the time, noting:

“Not taken medication for one month, has [illegible] lot of voices in his head. However calm, jocular, expresses odd ideas but not paranoid”.

The AOT was told on 21 January that Dr3 had seen Mr E. Mr E did not want to be admitted and Dr3 did not think MHA detention was necessary. As a result Mr E had been released without further action. The AOT spoke with Dr3, who said that Mr E was well and that he would be discussed at the next team meeting on 23 January. The AOT reviewed the Trust Approved Risk Assessment (TARA). The AOT tried to see Mr E at home but there was no reply.

The AOT staff conducted another home visit on 24 January. Mr E was not home but was seen walking down the road. A brief conversation took place in which Mr E appeared bright and stable.

Mr E went to A&E<sup>1</sup> on 25 January. He said that he was experiencing pain in his knee having kicked a wall the day before. The FY1 doctor (Foundation Year 1 posts are held by doctors in their first post-qualifying year) who saw Mr E did not record in the notes the reason given by Mr E for kicking a wall or how Mr E was feeling but found out that he had a significant mental health problem and recorded that “Mr E has a diagnosis of paranoid schizophrenia”. An x-ray showed no abnormalities and Mr E was discharged.

The AOT phoned Mr E on 27 January to arrange to meet with him the next day.

Mr E's care coordinator met Mr E on 28 January. Mr E said that he had stopped taking his medication because he did not believe he was schizophrenic, rather he had epilepsy and was not sleeping well. Mr E believed his hallucinations were caused by his antipsychotic medication. Mr E made veiled threats to the ward manager, presented with delusional thoughts about Ringo Starr, and was racist in

---

<sup>1</sup> The trust internal report says that Mr E was accompanied by the police to A&E on 25 January. However, the A&E notes say he was unaccompanied and the police told us that they did not see him on 25 January.

conversation. Mr E denied having thoughts about actually harming anyone specific. His care coordinator contacted the ward manager to inform him of Mr E's threats. He also spoke urgently with Dr3, who agreed to assess Mr E the following week. The AOT team office was informed of the developments.

Mr E was seen by chance by a member of the CMHT on 29 January when visiting another patient. Mr E acted in a bizarre manner, introducing himself as the patient's son. The staff member thought his behaviour was intimidating.

#### **4.8 30 January 2011**

Mr E cut his hand at home when smashing property on 30 January. He presented at the Salvation Army hostel with a serious hand injury at 08.18am. The hostel staff advised that he should go to hospital. He was described by hostel staff as talking a grandiose and irrational manner, saying he had been shot in 1997 and claiming to be other people. He subsequently left the hostel. The hostel duty manager was concerned about Mr E's behaviour and public safety, and therefore contacted A&E to check that Mr E had arrived. The hostel duty manager said that it was the first time she had felt vulnerable in his presence.

Mr E arrived at A&E at about 08.36am. He was loud and demanding. He did not book in and left the department before accepting any treatment for his hand.

A student nurse who knew Mr E saw him acting strangely on Molesworth Street at 09.10am. He had blood on his clothes. The student nurse contacted the police who in turn went to Mr E's home at 09.22am. They were concerned about his health and therefore forced entry into his home. The police accompanied him to the hospital, where he was registered at 10.14am. Mr E told A&E staff that he was under the care of psychiatry but would not give any further information. Mr E was treated for his hand injury and discharged. The police officer who had been with him reported that Mr E was calm and chatty.

The trust internal investigation states that a neighbour visited Mr E at 1.00pm. It was later reported by the neighbour that Mr E's speech had been irrational and delusional. At 8.00pm neighbours invited Mr E to a house party. They found his behaviour amusing. They left him at 10.00pm, inviting him to join them an hour later at a pub.

Mr E went to the Salvation Army hostel at 10.52pm and talked to staff. He then left.

Mr X, the victim, lived near the hostel. When Mr X walked past the hostel, Mr E attacked him and beat him in an unprovoked sustained attack.

Mr E returned to the hostel at 11.05pm saying that he had "killed [Mr X]". He struck and head-butted another resident who had seen the victim on the ground.

At 11.32pm another resident reported that there was a person on the ground in a pool of blood. The police and ambulance service were called.

The police arrested Mr E at his home at 11.55pm. He reported that he was confused as to his whereabouts and made strong racist comments. Similar comments were made to people entering the house later. Mr E continued to make inappropriate and delusional comments.

Mr E was subsequently detained under Section 3 of the MHA and transferred to the Edenfield Unit. He later admitted to the offence during a police interview but said that he was mentally ill at the time of the incident because he had stopped taking his medication.

## **5 Analysis of themes**

In the following sections of the report we provide our comments on and analysis of the themes outlined in the terms of reference and those that we have identified as part of our investigation.

We have focused our attention primarily on the last 12 months of Mr E's care prior to the incident on 30 January 2011.

The themes are:

- the formulation of diagnosis;
- risk assessment and risk management;
- care pathways;
- CPA and care coordination;
- discharge planning and aftercare;
- forensic services and MAPPA;
- drug and substance misuse;
- Mr E's presentation on 30 January 2011; and
- predictability and preventability.

## **6 Mr E's diagnosis**

In this section we consider Mr E's diagnosis and whether it was appropriately formulated and evidenced by those responsible for his care.

A diagnosis of Mr E's condition was first made in February 2008. His primary diagnosis was schizophrenia (usually paranoid schizophrenia). There is evidence to indicate that the diagnosis was reached after appropriate consideration of his clinical presentation. Successive letters and discharge summaries between February 2008 and December 2010 show that those responsible for Mr E's overall care were aware of his diagnosis.

There is a single exception to this diagnosis in December 2010 when Mr E was diagnosed with schizoaffective disorder. In this instance Mr E had clinical features consistent with the diagnoses of schizophrenia and affective disorder.

### **6.1 Analysis**

There is strong clinical evidence to support a diagnosis of schizophrenia. We have no criticism of this diagnosis. It is not uncommon for people with schizophrenia to also experience mood disturbance of sufficient severity, on occasion, to receive a diagnosis of schizoaffective disorder, but Mr E's primary mental health diagnosis was undoubtedly schizophrenia.

On nearly all occasions, reference was made to substance misuse issues when the diagnosis was formulated. This was appropriate, although formal ICD<sup>1</sup> coding was used only once. Each diagnostic formulation referred to Mr E's aggressive behaviour towards members of the public. Repeated reference was made to his violence and forensic history.

The only explicit mention of Mr E's personality in a diagnostic formulation was in May 2009, when Mr E was described as showing "dissocial personality traits". This was appropriate. It was consistent with his forensic history and with observations about his "manipulative behaviour" during his admission in October 2010.

Although a detailed diagnostic formulation does not appear in Mr E's clinical records, those responsible for his care saw him as a complex and difficult to manage individual with an enduring mental illness, namely schizophrenia, coupled with substance misuse problems with an additional history of significant and repeated violence towards members of the public. This was, in effect, the core diagnostic formulation that was shared between professionals managing him. It was fit for the purpose for which it was intended.

### **6.2 Finding**

Mr E's diagnosis of schizophrenia was appropriate.

---

<sup>1</sup> International classification of diseases.

## 7 Risk assessment and risk management

### 7.1 National and local policies

In this section we examine Mr E's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.

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

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

1. static factors – these are unchangeable, e.g., a history of child abuse or suicide attempts;
2. dynamic factors – factors that change over time, e.g., misuse of drugs or alcohol; and
3. acute factors or triggers – these change rapidly and their influence on the level of risk may be short-lived.

The trust updated its clinical risk assessment and management policy in 2013. However, for the purpose of this investigation, we refer to the policy in place at the time of Mr E's care.

The trust risk assessment policy (2010) states that all service-users should have a risk assessment as part of their overall assessment. Each service user should have a risk assessment that covers:

- “risk of suicide and/or self harm;
- risk of self-neglect;
- vulnerability to exploitation or abuse of others; and
- risk of harm to others (including children)”.

It adds that drug and alcohol use should be taken into consideration across each domain. The policy states that risk reviews should take place regularly. It highlights factors that may prompt a risk review which include “hospital admission, leave or discharge”.

#### 7.1.2 Comment

The trust risk assessment policy contains a useful discussion about how to approach a clinical risk management plan.

## 7.2 Risk assessment

It was well documented by the trust that Mr E had a long history of violence and criminal convictions in Ireland and England. The trust internal report highlighted that he had an extensive offender history, including assault, and had served custodial sentences. It also highlighted a number of features that would have been included in Mr E's diagnostic formulation:

- Mr E had experienced psychoses with paranoid ideation, delusions and intrusive thoughts of violence towards named others. He had experienced command hallucinations to harm others;
- Mr E was vulnerable to relapse;
- Service personnel had difficulties in sustaining contact, monitoring Mr E's mental state and needs, and ensuring medication compliance;
- Mr E was vulnerable to anxiety and panic attacks with some degree of avoidance;
- Mr E was at times impulsive, volatile and unpredictable;
- Mr E had a long history of offending behaviours involving violence, including assaults on strangers for which he served custodial sentences; and
- Mr E engaged in the misuse of substances, including cannabis, cocaine, skunk and alcohol with episodes of bingeing.

We reviewed the 12 risk assessment forms in the old format (STAR) completed for Mr E between January 2008 and May 2010. Most of the risk assessments were completed when Mr E was an inpatient. On every occasion the following factors were identified: mental illness; non-compliance with medication; relapse risk; and violence.

On almost every occasion explicit mention was made of the following features in the violence section:

- current thoughts/plans or symptoms indicating a risk of violence or harm to others;
- current behaviour suggesting risk of violence or harm to others;
- current problems with alcohol or substance misuse;
- expressions of concern by others about risk of violence;
- evidence of disinhibited behaviour; and
- forensic history.

Steps were taken by adult mental health services in 2008 to obtain information about Mr E's care in Ireland. A locum consultant forensic psychiatrist wrote to the CMHT on 13 June 2008 to advise that he had written to the Central Mental Hospital in Dublin to get background information about Mr E. Although it is unclear whether there was a response to that letter, detailed information about Mr E's mental health and offending history in Ireland was available to the forensic services by 2009.

Mr E's risk assessments recorded that he had a forensic history. In a risk assessment undertaken in October 2009 it said:

“Substance misuse increases risk of violence. Poor anger management skills that can lead to violence. Known to carry weapons. To be seen in twos. [Mr E] is aware of the risk he presents. Has been recommended for Medium Secure Unit in the past”.

Mr E’s AOT worker used a modified risk assessment form (TARA - which replaced the STAR form) on 10 September 2010 and arranged his immediate admission to hospital after its completion.

He identified 14 risks in relation to harm to others/violence, including:

- incidents of violence and aggression;
- expressing intent to harm others;
- forensic history;
- carrying weapons/use of weapons;
- paranoid delusions about others;
- violent command hallucinations;
- preoccupation with violent fantasy;
- signs of anger; and
- sexually inappropriate behaviour.

In a risk assessment conducted on the ward on 22 October 2010, hours before Mr E left hospital, it was recorded:

“[Mr E] continues to express the feeling that he wants to harm someone, just because they may look at him the wrong way. [Mr E] states he is a dangerous person and goes into another character. He says this feeling comes over me and I plan what I would do to them... [Mr E] was advised that this would be classed as premeditated and not mental illness... Currently no evidence of psychosis, [Mr E] has not expressed any delusional beliefs, no evidence of paranoia”.

The risk assessment added that there was no evidence of alcohol or substance misuse and that Mr E was not expressing any delusional beliefs or evidence of psychosis.

### 7.2.1 Analysis

Good electronic record systems reduce the risk of assessments not being accessible; however, these were not in use at the time Mr E was seen.

We have seen no evidence that front-line medical or nursing staff were advised by those managing Mr E to review his previous or more recent paper-based risk assessments. This might have reflected limitations in briefing new staff about his risk profile or that recording such background briefing was thought unnecessary.

After Mr E’s discharge from hospital on 22 October 2010 he returned to the community under the care of the AOT. There is no record that a subsequent risk

assessment was undertaken by AOT from that point onwards, prior to the incident on 30 January 2011. This represents a serious oversight, not because Mr E's risk profile was unknown, but because his effective community risk management depended on reliable up-to-date information.

#### 7.2.2 Finding

There is no evidence that Mr E was subject to a systematic risk assessment after his discharge from hospital in October 2010.

### 7.3 Risk Management

A full risk assessment is of little value unless linked with an appropriate and realistic risk management plan. The trust's policy makes this point and sets out where the risk management plan should be recorded.

None of Mr E's 15 risk assessment forms that were reviewed provides a systematic risk management plan for his management in the community. Those forms that were completed when he was in hospital largely emphasise the need for him to remain in hospital as a means of preventing violence or harm to others in the community.

Clinicians working with Mr E did not have access to an effective written risk management plan that reflected his risk assessment. This indicates a failure to comply with the trust's policy on risk assessment and management.

#### 7.3.1 Finding

Clinicians working with Mr E did not have access to an effective written risk management plan that reflected his risk assessment.

### 7.4 Hospital admission

Hospital admission was used as part of Mr E's management from late 2008 onwards. He was admitted in response to escalation of his paranoid and threatening symptoms, as a means of reducing the risk of immediate harm to others.

#### 7.4.1 Analysis

This element of Mr E's management was appropriate. It was successfully used in 2009 and on two occasions in 2010. We commend Mr E's care coordinator who assessed and arranged for his admission in September 2010 as a means of preventing harm to the public. During the admission, risk assessments were repeated and adjustments made to Mr E's medication and leave in response to changes in the perceived level of risk. This was also appropriate.

However, apart from physical containment in hospital as a means of reducing risk of harm to others, Mr E's management plan during both admissions in 2010 failed to address many of the contributory features linked with his risk of violence. For example, although he was given oral antipsychotic medication on the ward, there is no evidence that a management plan was devised to address his repeated non-compliance in the community.

Similarly, there is no evidence that the recurrent and serious problem of substance misuse (outside of inpatient admissions) was included in his management plan. Mr E's sexually inappropriate and manipulative behaviours seen in hospital and considered to be significant risk factors were also not addressed as part of his clinical management plan before his community discharge.

## 7.5 Ward Discharge

The consultant psychiatrist interviewed Mr E a week prior to his discharge in October 2010. Features of his mental state were recorded. These included being "angry, hostile, accusing workers of not listening to him (when he was demanding zopiclone), admitted to attacking an acquaintance two weeks ago"; "repeating his ideas of attacking the people who had offended him prior to admission, specific people but did not identify them, talking about the possibility of shooting them".

Mr E allegedly slapped another patient in the face three days later on 18 October. The consultant psychiatrist reviewed him the next day. He said that "he intends to contain his aggressive behaviour in the future". The consultant thought there was some improvement in his mental state on a higher dose of olanzapine but cautioned "in some ways this is not very reassuring" and discussed a change from olanzapine to clozapine<sup>1</sup> with Mr E but he refused a change in medication. Mr E was discharged four days later on 22 October despite his consultant noting that Mr E "uses power as a way of controlling people in his conversation".

We explore the threshold for discharging Mr E in more depth under 'discharge planning/after care'.

### 7.5.1 Analysis

The failure to formulate an appropriate risk management plan during Mr E's admissions in 2010 was compounded by the absence of a coherent discharge and community care management plan. Although an AOT worker attended the ward round on the day of his discharge on 22 October 2010, he had not managed Mr E previously (and Mr E subsequently refused to engage with him). No detailed care plan with contingencies was prepared, and Mr E's risk assessment was not repeated. It is unclear whether the new AOT worker read the records made by the consultant just days previously, which reflected Mr E's high continuing risk.

---

<sup>1</sup> An antipsychotic for treatment-resistant schizophrenia

There is no indication that a structured risk assessment was used in the formulation of Mr E's community management plan after his discharge in October 2010. There was not a care plan in place that explicitly addressed his risk of violence – this should have been written in compliance with the trust CPA requirements.

In practice, Mr E's management plan involved regular contact with the AOT team, provided they could identify an appropriate location to meet – they were reluctant to see him at home – and encouragement to continue taking his antipsychotic medication. In addition, the AOT offered Mr E practical support with his cats and finances at his request. The frequency or nature of AOT contact was not explicit and ranged from once/twice a week to every two weeks or slightly longer over the following three months.

#### 7.5.2 Finding

On his discharge from hospital, Mr E did not have an appropriate and explicit risk management plan for his community management in October 2010. This was a serious omission.

### 7.6 Medication

We contacted Mr E's GP surgery to discuss his medication in the months before the incident as Mr E told us that he did not receive his olanzapine medication during the period close to the incident (he did not give an exact time frame). He said that he assumed his medication had been changed. We were told that Mr E's medication was prescribed by his GP. Mr E was responsible for requesting renewal of all or part of his prescription when he thought it necessary. It was then his responsibility to collect the prescription once dispensed and self-administer at home.

Mr E requested fresh supplies of these medications on the following dates:

- Clonazepam 500mcg tablets x 112 on 28 October 2010, 24 November 2010, 20 December 2010 and 21 January 2011
- Olanzapine 20mg tablets x 28 on 28 October 2010, 24 November 2010 and 20 December 2010
- Zopiclone 7.5mg tablets x 28 on 28 October 2010, 24 November 2010, 20 December 2010 and 21 January 2011

#### 7.6.1 Analysis

We found no evidence of a GP decision to recommend olanzapine dose reduction or cessation in the month prior to the incident. Mr E simply did not request a fresh supply of olanzapine on 21 January 2011. We cannot know why Mr E did not request a refresh; he may well have had a residual supply of unused medication at home, in any case. There is evidence that he had on occasion failed to take olanzapine medication reliably in the past. Mr E told his care coordinator on 28

January that he had stopped taking his medication. We conclude there was a system in place for Mr E to be regularly supplied with his medication.

## **8 Care pathway**

In this section we consider whether Mr E's pathway of care was appropriate, given his diagnosis and presentation.

Mr E required antipsychotic medication to treat his schizophrenia. The purpose of this was to reduce/eliminate the paranoid delusions and paranoid command hallucinations he experienced when unwell.

There is evidence that Mr E's psychotic symptoms improved when treated with antipsychotic medication during each of his hospital admissions between 2008 and 2010. Recurring compliance problems with oral antipsychotic medication arose when Mr E was based in the community. His medication was prescribed by his GP but taking it was Mr E's responsibility.

### **8.1 Comment**

Antipsychotic medication was a central part of Mr E's treatment plan. This was entirely appropriate and an essential part of his care pathway.

### **8.2 Analysis**

There is no indication that serious consideration was given in 2009 or 2010 to the use of long-acting injectable antipsychotic medication ("depot"). This can be valuable where sustained compliance with oral medication is a problem. It is possible that Mr E would not have consented to depot. In these circumstances he would have required detention under the MHA in hospital (as happened in March 2010) with subsequent use of a CTO for his community management.

Mr E was a complex community patient who had informal and formal admissions in 2010. Managing Mr E in the community had been a long-standing issue for the AOT and we are surprised that at no stage during 2010 was the use of a CTO considered. It was known that Mr E was a continuing risk in the community and that his compliance with medication was variable.

There is no record of a professional discussion about the use of a CTO to support Mr E's community management in 2010. It is by no means certain there would have been professional agreement on the use of this power because of doubt about its "workability" and concerns that Mr E would not adhere to it. However, not to have considered this pathway in Mr E's care – be it as part of a CPA review or on the ward – was a serious omission. In addition there is also no evidence that Mr E's substance misuse was actively addressed or that an explicit referral to a substance misuse service was made or discussed with Mr E. We discuss this further under "Drug and substance misuse".

After his discharge in October 2010 (which we discuss in greater depth under "Discharge"), Mr E's care plan appeared to be primarily one of attempting to maintain

contact with him on a semi-regular basis to provide low-level monitoring of his mental state, and to assist him with tasks such as the care of his cats and addressing financial issues. In the absence of an appropriate or effective care pathway for Mr E, there was little to inform an appropriate professional response to developments in January 2011.

### **8.3 Finding**

Mr E's care pathway did not comprehensively explore alternative care options for him and was not effective.

## 9 CPA and care coordination

In this section we examine whether Mr E met the criteria for CPA and whether he was allocated a care coordinator. We also examine the effectiveness of Mr E's care plan and whether he and his family were involved in care planning.

The trust CPA policy used at the time<sup>1</sup> that Mr E was in its care states that:

“The CPA policy is applicable to all adults of working age in contact with the secondary mental health system (health and social care).”

It also states that:

“... the CPA should be applied to all those who present to drug and alcohol services with a co-morbid mental health problem of a severity that warrants care and treatment from the specialist mental health service. Care co-ordination of these clients will be managed within specialist mental health service and not drug and alcohol service.”

The policy outlines a number of characteristics to consider, including the severity of the mental disorder and risk factors including:

“suicide, self-harm, harm to others (including history of offending), relapse history including urgent response and self neglect/non-concordance with treatment plan... presence of non-physical co-morbidity, e.g., substance/alcohol/prescription drugs... multiple service provision from difference agencies, including: housing, physical care, employment, criminal justice, voluntary agencies...”

The trust policy highlights that national guidance identifies key individuals who need CPA, including those:

“...with a history of violence or self-harm.”

Mr E met the trust criteria for CPA. He used mental health services, had a history of violence, and was known to abuse drugs and alcohol. In addition, other agencies such as housing were engaging with him.

Mr E was first put on CPA in February 2008. He had a number of care plans, including those for when he was admitted to Hollingworth ward and a care plan created by the CRHT when he was briefly under its care in October 2010.

Mr E had one care coordinator throughout his care at the trust. During the later stages of his care, the care coordinator felt “burnt out”, and steps were taken to replace him. However, Mr E would not engage with the replacement, so he was returned to the caseload of his original care co-ordinator. During his interview with the internal investigators, Mr E's care coordinator emphasised Mr E's drug abuse

---

<sup>1</sup> The trust revised its CPA policy in December 2012.

(and the subsequent impact on his mental health), poor engagement with treatment and poor compliance with medication.

The care coordinator said that he felt the team was “monitoring” Mr E and that there was little evidence of his recovery. Their pattern of contact with him was largely down to the fact that Mr E would not engage with the service unless he needed something. He added that the team managed Mr E as best they could considering his drug use and transient lifestyle.

## **9.1 Analysis**

Mr E’s last CPA review took place on 22 October 2010, the day of his discharge from hospital. There was no further CPA review despite indications that his behaviour was deteriorating. For example, in November 2010 he told AOT he had been bingeing on crack cocaine. Just over a week later he required a crisis loan to cover gambling debts.

The AOT failed adequately to address the difficulties that Mr E’s care coordinator was experiencing even though the whole team played a part in monitoring Mr E. When Mr E refused to engage with his new care coordinator he was simply returned to the caseload of his original care worker. This was not a solution to the problem.

After his discharge from hospital in October 2010, Mr E was subjected to what we consider a “light touch” care plan. This was despite the historic risks that were known to the AOT. The internal investigation highlighted that clinical and management supervision of the case during this period was not effective.

## **9.2 Finding**

We found no evidence of a robust multi-professional review such as a CPA review following Mr E’s discharge from hospital in October 2010.

## **9.3 Comment**

The CPA policy states: “We welcome people, their families and carers to be involved in various ways”.

Mr E’s family were not known to the trust. It was recorded in his notes that he grew up in Ireland and had been raised by his stepfather. As a result, members of Mr E’s family were not involved in his care.

## 10 Discharge planning / after care

In this section we consider if appropriate arrangements were in place for Mr E after his discharges from hospital in 2010.

According to the trust CPA policy:

“both admission as an inpatient and impending discharge should trigger a review (inc risk assessment) and the completion of an updated care plan (inc crisis risk management and contingency plan)... All service users should be provided with a written discharge/care plan formulated and agreed with prior to discharge, ideally at a multidisciplinary meeting. For those on CPA this should be part of the CPA wellbeing care plan”.

The policy outlines what should be considered as part of the discharge arrangements, and states that services users should be followed up in person within seven days of discharge from hospital.

Mr E was admitted to Hollingworth ward twice in 2010. In March he was admitted under Section 136 of the MHA (this was converted to Section 2 and subsequently to Section 3). He remained an inpatient until May 2010. A risk assessment was undertaken with Mr E when he was discharged in May.

He was admitted again in September and discharged later the following month (on 22 October).

The AOT took steps to see Mr E within seven days of both discharges. In May 2010 it made contact and subsequently saw him. In October 2010 it failed to see him despite attempts to make contact. This led to a breach in the seven-day follow-up requirement; consequently the AOT team manager became involved. The team increased the frequency of visits undertaken in an attempt to see Mr E. After further failed attempts to see him the police were contacted who undertook a welfare visit. Mr E was not seen during the latter although a neighbour confirmed that Mr E had been seen the previous day.

### 10.1 Analysis

Although an AOT worker attended the ward round on the day of Mr E's discharge from hospital on 22 October 2010, he had not previously managed him. Mr E refused to engage with him. No detailed care plan with contingencies was prepared. Mr E's risk assessment was not repeated.

The decision about appropriateness and timing of Mr E's discharges from hospital was never easy. It is clear that the “threshold” for discharge was fairly low in 2010, as for example in October when he was discharged days after exhibiting significant paranoid and psychotic symptoms, which included threats towards others. The internal investigation report makes the valid observation that Mr E's unpleasant and at times abusive and threatening behaviour towards staff in hospital created an

atmosphere, of which the professionals were aware, in which there was pressure to discharge him.

When Mr E pressed for a discharge, as he did in October 2010, the alternative options were limited. Mr E could either leave hospital and be followed up on by the AOT (as happened) or detained under the MHA with a view to exploring longer-term options such as a CTO.

If Mr E had been detained, his management would have been difficult in most acute psychiatric wards because of his challenging and anti-social behaviour. In such an environment it would have been difficult to establish effective boundaries and an effective treatment regime to reduce undesired behaviours and prepare him for discharge.

We have previously outlined that an appropriate explicit risk management plan was not in place. Despite this, the clinical records show that the AOT routinely attempted to engage with Mr E both before and after he was discharged from the ward.

## **10.2 Findings**

The threshold to discharge Mr E from hospital in May and October 2010 was lower than a realistic risk assessment would indicate.

The AOT took active steps to engage with Mr E after his discharges from hospital in March and October 2010.

## **11 Forensic services and MAPPA**

### **11.1 Forensic services**

Mr E had an extensive forensic history and a number of criminal convictions (including for assault), for which he received custodial sentences.

Mr E met the criteria for the involvement of forensic services in January 2008 when he was assessed as an inpatient by a member of the MDO team. There was liaison with the police and Mr E was taken into custody upon discharge. He faced charges related to jumping bail and a recent assault. Mr E was subsequently remanded in custody in respect of a series of assaults and in April 2008 was convicted of three offences. Mr E was appropriately assessed by the forensic psychiatric service when in prison, and treatment with antipsychotic medication was endorsed by the service. The forensic service obtained valuable information from the Irish psychiatric services about Mr E's mental health and forensic history.

In May 2008 the forensic psychiatric service proposed transferring Mr E from prison to a PICU, but no beds were immediately available. In July 2008 it was thought that a medium secure unit placement would be more suitable, but Mr E had served his sentence and the court decided that a transfer under the MHA was not appropriate. Mr E was released from prison on probation.

A joint visit by the MDO team and the AOT was made after his release. His subsequent community management became the responsibility of the AOT without any continued MDO team or forensic services involvement. Their involvement ceased because Mr E was not facing any further criminal charges.

In March 2010 Mr E was detained following an arrest for an alleged assault and admitted to hospital. A referral was made to the MDO panel. The panel was told that the police were not intending to charge Mr E. The panel decided that there was no need for further involvement by the MDO service. Although concerns about Mr E's violent behaviour and substance misuse persisted throughout 2010, further forensic service advice was not sought. After his discharge in April 2010, Mr E was managed by the AOT in the community.

#### **11.1.1 Analysis**

In light of the seriousness of Mr E's known risk of violence to others, the failure to press the forensic services to provide further advice in late 2008 and subsequently on the management of his risk in a community setting was a failing. However we note that the absence of further criminal charges against Mr E was seen by the MDO team as an obstacle to further engagement.

The forensic services may have been able to provide AOT with helpful advice on Mr E's management if they were asked. Forensic services have considerable experience of individuals whose personality, pattern of offending and nature of psychotic illness complicated by drug misuse present a challenge to local services.

### 11.1.3 Findings

The AOT did not refer Mr E to forensic services for assessment or seek their advice on management.

Mr E was referred to the MDO team in 2008 and 2010. On neither occasion was he accepted into the team's caseload as he did not meet their referral criteria.

## 11.2 MAPPA

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

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

“Category 1 – Registered sexual offender

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

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

Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Sch.15 of the CJA 2003.”

The trust internal report noted that the criteria for MAPPA referrals which operated locally at the time were unlikely to have provided much assistance in this case. In July 2008 the MDO team agreed to make a referral to the local MAPPA panel but there is no evidence that it provided helpful advice. Mr E's offending history meant that he did not meet the threshold for Category 1 or 2 and may not have met that for Category 3. Not seeking further MAPPA advice was not a failure in Mr E's care.

---

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

## **12 Drug and substance misuse**

Throughout Mr E's care, the trust recognised that his misuse of a range of illicit drugs usually had an adverse effect on his mental state. He was not addicted to alcohol or opiates, but repeatedly sought illicit drugs during his stays in hospital and when in the community. It was not generally thought that his psychotic illness was primarily caused by substance misuse, but it exacerbated his symptoms.

### **12.1 Analysis**

Such a clinical scenario is not rare in community mental health services. Effective clinical management of such patients can be challenging. In many mental health services in 2010 input from specialist substance misuse services in managing patients like Mr E was limited or non-existent in cases where the primary mental disorder was schizophrenia. This often reflected both resources and local policy, influenced by the fact that many patients, such as Mr E, are not motivated to address their substance misuse problem, particularly once they have returned to the community.

Inpatient services could have taken the opportunity to seek advice from the drug misuse service during Mr E's admissions in 2009 and 2010. Mr E may have been more accessible when in hospital, and suggestions could have been made to assist subsequent AOT community management.

However, in the circumstances the trust cannot be criticised for failing to liaise with the drug and substance misuse service in 2010.

## 13 Presentation on 30 January 2011

On the morning of 30 January Mr E was noted by Salvation Army staff to have a bleeding hand and to be acting in a grandiose and irrational manner. They told him to go to A&E. Mr E attended A&E where he was loud, demanding and left before booking in, although there is no record of this. He was then seen on a road acting strangely and with blood on his clothes by a student nurse who contacted the police.

Police attended Mr E's house at 9:22am and subsequently escorted him by ambulance back to A&E for treatment to his hand. The trust internal report panel described itself as "puzzled" that the police officer escorting Mr E did not detect any signs of deteriorating mental illness and that Mr E was described as calm and chatty. This was in direct contrast to the presentation described by Salvation Army staff and the student nurse. The panel was unable to speak to the police officer in question about this.

The doctor who reviewed Mr E in A&E noted that he was under the care of psychiatry but did not explore this further. There is no record to suggest that mental health services were contacted. A&E intervention was limited to treating Mr E's physical problem.

It was noted in the trust internal report that there had been problems between A&E and mental health services, although individual relationships were good. A&E services have been restructured since the incident in January 2011<sup>1</sup>.

### 13.1 Analysis

There is no indication that A&E staff had concerns about Mr E's mental state in the short time that he was seen. In these circumstances there was no obvious need for A&E staff to seek immediate mental health advice. Almost certainly there would have been a significant delay in obtaining the attendance of a mental health professional. A&E departments must make judgements on a daily basis as to the benefits/disadvantages of engaging with mental health services. We have no criticism of the A&E department staff.

Our sole reservation would be if mental health services had previously provided information about Mr E's risks to A&E. Such steps are taken in rare circumstances but we found no evidence to indicate that this had happened in this case.

In this case, Mr E was escorted to A&E by the police, who may have had relevant information about his risk. This potentially could have triggered further enquiries by

---

<sup>1</sup> A&E services for the Rochdale area have since been transferred to Fairfield Hospital in Bury. The trust has implemented a new model of care called the Rapid, Assessment, Interface and Discharge (RAID) model. The model of care is geared towards individuals with mental health and alcohol problems. It offers 24-hour availability of consultant and liaison support to A&E, medical assessment units (MAUs), medical, maternity and surgical wards.

A&E to mental health services. However, there is no evidence that the police made such communication.

### **13.2 Finding**

A&E staff acted appropriately on 30 January 2011.

## 14 Predictability and preventability

In this section we consider whether the incident was predictable or preventable.

### 14.1 Predictability

In reaching a conclusion about predictability and preventability we set out below the standards against which we have assessed Mr E's care.

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

We believe that, although Mr E's potential for violence was predictable, the extent of it was not.

Mr E had a history of violence, and that violence was known to be exacerbated by alcohol and substance misuse. In the days leading to the incident there were changes in his behaviour. Between 20 January and 30 January 2011 there were a number of instances in which it was noted that he was acting unusually:

- On 20 January Mr E was arrested for criminal damage. He tested positive for cocaine. He was subsequently subject to an MHA assessment. The consultant psychiatrist deemed Mr E did not need to be admitted.
- On 25 January Mr E went to A&E to receive treatment for pain in his knee. He had reportedly kicked a wall the day before.
- On 28 January when seen by his care coordinator Mr E appeared delusional and had stopped taking his medication. The care coordinator contacted Dr3 for advice. This was the same consultant psychiatrist who had assessed Mr E after his arrest on 20 January. He agreed to see Mr E the following week.
- Mr E was seen by chance by a member of the CMHT on 29 January. He was noted to be acting in a bizarre and intimidating manner.

Further to this, though, AOT staff were not aware that on 30 January 2011:

- Mr E attended the Salvation Army. He appeared disturbed with bleeding from a cut to his hand. Staff told him to go to A&E and contacted the department to check that he had arrived.
- Mr E went to A&E. He was noted to be loud and did not book in.
- Mr E was seen walking along a road by a student nurse, who noted that he was acting in a bizarre manner and had blood on his clothes. The student nurse contacted the police.

- Police attended Mr E's home and escorted him to A&E to receive treatment to a cut on his hand. A&E staff recorded in his notes that he was under the care of psychiatry.

There is no record to indicate that during these incidents Mr E said he intended to harm another person. AOT staff tried to see Mr E on a number of occasions in January but with limited success. He typically wasn't at home when the team visited and declined more than once to have a meeting.

Taking into account Mr E's forensic and clinical history, and the cumulative nature and frequency of concerns about him, it was reasonable to predict that he would be violent but the timing, the severity and the target of his violent behaviour was not predictable.

#### 14.1.1 Finding

We find that, while it could have been predicted that Mr E would be violent, the extent to which his violence would escalate could not have been foreseen.

### 14.2 Preventability

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

There were a number of occasions in January 2011 where actions could have happened that may have prevented the incident:

- On 20 January Mr E was assessed by Dr3 in police custody with a view to admission as recommended by the forensic medical examiner. Mr E could have been admitted to hospital but Dr3 did not believe this was necessary. Dr3 decided that Mr E could be cared for in the community.
- On 24 January Mr E was seen briefly by two AOT workers who did not know him well. The AOT workers could have carried out a full assessment, but this did not take place.
- On 28 January Mr E was assessed by his care coordinator, who subsequently took provisional steps to arrange a bed for him. He contacted Dr3, who advised that he would see Mr E after the weekend.
- On 30 January Mr E attended A&E accompanied by the police. If the police had been aware of Mr E's risk history and given it to A&E staff, a mental health assessment may have been arranged.

On each of the above occasions, those involved either did not believe Mr E warranted admission or were unaware of the potential risk he posed. As a result we

do not believe that there was an occasion when the knowledge, legal means and opportunity were available to professionals but that they failed to act.

We have considered the actions taken on 28 January in further depth. We commend the actions of Mr E's care coordinator, who was obviously concerned about Mr E's mental state in contacting the ward and Dr3 for advice.

The decision of Dr3 not to see Mr E that day was a clinical judgement. Dr3 knew Mr E well and had seen him less than a week before the incident. He was aware that Mr E had a volatile streak and that admission was not the sole option of management available to the health professionals.

As a result of the above we believe that it was reasonable of Dr3 to delay the review of Mr E until the following week. We conclude that the incident on 30 January could not have been prevented.

#### 14.2.1 Finding

We found that the death of Mr X could not have been prevented.

## 15 The trust's internal investigation report

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

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

### 15.1 National guidance

The NPSA good practice guidance *Independent investigation of serious patient safety incidents in mental health services*<sup>1</sup> (2008) outlines three steps in the independent investigation process, two of which are the responsibility of the trust. These are to undertake an initial service within 72 hours of the incident being learnt of, and to complete an internal investigation using root cause analysis (RCA).

The NPSA produced *Root cause analysis investigation tools – Three levels of RCA guidance* (2008). It lists three levels of RCA and states that a level 2 (comprehensive investigation) should be:

“Commonly conducted for actual or potential ‘severe harm or death’ outcomes from incidents, claims, complaints or concerns”;

that the investigation should use:

“Appropriate analytical tools (e.g. tabular timeline, contributory factors framework, change analysis, barrier analysis)”;

and that it is:

“Normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred”.

### 15.2 Trust policy

The “Incident reporting, management and investigation policy” in force at the time of the incident was dated June 2010. The trust has since reviewed the policy and circulated a revised version in October 2012. For the purpose of our investigation, we have referred to the 2010 policy that the trust investigators were working under.

The policy states that an initial management review should take place within 72 hours of the incident. The policy says that grade 5 incidents (those which are life

---

<sup>1</sup><http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156>

threatening or result in death) should be subject to a formal internal investigation. In addition, it states:

“If the directors feel that further investigation is required they will direct that an Internal NHS Mental Health Trust Investigation is commissioned, using a root cause analysis approach (RCA)”.

In conjunction with this type of investigation the trust provides a root cause analysis investigation protocol.

### **15.3 Detection of the incident**

The CMHT received a fax from the emergency duty team (EDT) on 31 January 2011 informing it that Mr E was in custody at Chadderton police station on suspicion of attempted murder. It was later reported that the victim died at 06.40am the same day. The police doctor believed that Mr E was under the influence of drugs and/or alcohol. The AOT confirmed these details with the police at 08.52am on 31 January.

### **15.4 Trust internal investigation**

We were told that the service would not have submitted a 72-hour report. However, the information-gathering process would have commenced upon notification of the incident, which would have fed into the trust internal review.

The trust commissioned an internal review into the care and treatment of Mr E. This review began in March 2011. The investigation team consisted of:

- independent health care advisor (panel chair);
- medical director, Greater Manchester West Mental Health Foundation Trust;
- medical director, Pennine Care NHS Foundation Trust; and
- deputy director of nursing and integrated governance, Pennine Care NHS Foundation Trust.

The terms of reference for the internal review included the examination of the care and treatment of Mr E, the adequacy of risk assessments, and the communication and information-sharing among/between internal and external agencies about Mr E.

The internal investigation team reviewed Mr E's clinical notes, trust policies and procedures, and interviewed a number of staff involved in Mr E's care. The panel met with the family of the victim during the course of the internal investigation. Details of Mr E's family were (and remain) unknown.

The investigation report contained a detailed chronology and explored a number of areas, including case management, clinical issues, inpatient care and links with other services/agencies.

The panel held a “Learning the lessons” workshop in January 2012. This was attended by managers and clinicians from the trust along with representatives from

the police, the Salvation Army, the trust's former A&E department and the acute trust A&E. The workshop explored clinical issues, interagency/professional working, leadership and governance.

## **15.5 Analysis**

The trust internal investigation conducted an RCA approach as guided by trust policy. The report was comprehensive and addressed the terms of reference. The report authors set out a detailed chronology, relevant benchmarks, analysis of key events, findings and recommendations. The report identified areas of concern and omissions. Although there were some minor errors relating to dates, these did not have an impact on content or analysis.

The trust internal investigation panel acknowledged that it took considerably longer than anticipated to complete the investigation (breaching trust timescales). The delay was attributable to a number of factors, including the unavoidable absence of the panel chair owing to family illness. The panel added that, despite this, it believed that the investigation interviews and learning lessons workshop were held within a reasonable timeframe.

We discussed the investigation with the chair of the internal investigation panel. He told us that there were some areas that the panel would have liked to explore in greater depth, such as the review of Mr E by A&E staff on 30 January 2011. However, the A&E service had since closed and it was not possible to speak to the assessing doctor (although A&E managers were interviewed). Additionally he said that the panel had been unable to speak to the police officer who accompanied Mr E on 30 January 2011 despite attempts to arrange this.

We note that the trust internal report stated that Mr E was referred to the MDO team once. The internal report made a recommendation around links to forensic services and awareness of MDO's capacity. During our review of the records, we found that Mr E was referred twice: once in 2008 and again in 2010. The internal report does not reflect either this (we assume that the record was not seen/unavailable) or the fact that the AOT tried to engage with the MDO team. It was the decision of the MDO team not to accept Mr E. The trust internal report said that the police escorted Mr E to A&E on 25 January. We could find no record of this and the police told us that this had not happened.

## **15.6 Finding**

The trust internal investigation fulfilled the terms of reference, was comprehensive and in line with trust policy.

## 16 The trust's progress made against the internal investigation

### recommendations

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

The report identified several areas that needed improvement and made 13 recommendations, although it added that:

“In essence... one might identify the main concerns seen in [Mr E's] care as being associated with:

- the need to integrate relevant information gathering with information recording; and
- reflecting and processing that information within a sound clinical knowledge base”.

The recommendations are summarised below – a full copy of the recommendations can be seen in appendix B.

- 1) Changes in mental health and risk presentation should be reviewed and evaluated by the care coordinator and documentation updated/communicated accordingly.
- 2) Risk assessment should inform the management plan, which should be updated regularly by significant clinical events.
- 3) Clinical leaders should hold overall responsibility for contemporary risk assessments and comprehensive care planning.
- 4) A – There should be a full formulation of need and detailed care plans for patients who are difficult to engage.  
B – The role of the care coordinator should be central to continuity of care.
- 5) The trust should consider how to develop more sophisticated approaches to ensuring concordant therapy.
- 6) The trust should review and evaluate its current substance misuse strategies and policies.
- 7) The trust should further explore links with forensic services, MAPPA forums and MDO.
- 8) Staff development programmes should extend to health promotion and physical wellbeing.
- 9) A – Inpatient care should provide an opportunity to re-evaluate the patient, formulation and risk assessment.  
B – Strong leadership on inpatient units should be used to manage difficult patients who in turn may engender unpopularity on the unit and calls for early discharge.
- 10) Engagement between trust and police services to review current liaison protocols and joint training opportunities
- 11) Expansion of clinical supervision to include scrutiny of care coordination, risk assessment, practice and documentation.

- 12) A – The trust should develop its managerial and clinical supervision policy and procedures.  
B – Development of supervision process.  
C – Staff should be reminded of their own professional accountability for accessing clinical supervision.
- 13) Workforce, training and development priorities and needs.

An action plan was developed to take forward the recommendations. Each recommendation was allocated to a lead person and a timescale was identified. A copy of the trust action plan can be seen in appendix C. The trust grouped the recommendations into 10 areas of concern:

- risk assessment;
- management of high-risk service users who are difficult to engage;
- medicine management;
- substance misuse;
- links with forensic services;
- physical health care/health promotion;
- inpatient care for difficult-to-manage clients;
- police liaison;
- clinical and managerial supervision; and
- training.

The trust put together more than 30 action points to address the 10 areas.

## **16.1 Service restructure**

The community reconfiguration project began in 2010. Changes to the service were taking place during the period of Mr E's care.

We met with the lead for integrated services (mental health) and the service director for the North division to discuss the trust's progress against the action plan. We asked them to provide evidence of the trust's progress.

We were told that the mental health service has been restructured and is now divided into a borough-specific model; the boroughs are Rochdale, Heywood and Middleton, East and West, and South. Each sector operates a multidisciplinary team model with a named consultant psychiatrist. There are no longer separate AOTs and the services were described to us as more integrated.

They explained that the trust has a long-term strategic plan designed to overhaul its mental health services – this is the “Transformation of Community Mental Health Services” project, which is scheduled for completion by 31 March 2015.

## **16.2 CPA, risk assessment and service user management**

The trust is developing “CPA plus” specifically for high-risk patients such as Mr E. It will address the concerns identified by the trust internal investigation in relation to CPA and risk assessment; it will be the main vehicle to implement changes in care from the action plan. CPA plus will focus on those requiring more intervention, a multidisciplinary approach and multi-agency input. It will have triggers which will lead to a patient being placed on it. Patients will be able to move on and off CPA plus according to their need.

The trust gave us copies of the new “point of assessment documentation” (PAD) for mental health and the assessment proforma.

The trust is introducing zoning (similar to a traffic light system) in which it will be easier to identify high-risk patients and in which the whole team will be involved. There will be a tighter assessment framework for the CMHTs aimed at improving consistency. Zoning is also designed to improve communication across the teams.

We were told that the trust has developed an escalation process for difficult-to-manage patients if they are hard to locate. Staff will now attend the patient home and areas the patient is known to frequent, and that staff will do this at different times of day.

We were told that medical leadership has changed and that there is now closer association between the medical staff and community teams. In the new design, the consultant psychiatrist will lead the team and each patient will be seen by a psychiatrist.

The trust is introducing a new electronic management system called PARIS. All patient information will be recorded electronically – staff will have tablets to facilitate this. Risk assessments will be available on PARIS and staff will be able to view historic information. New patient information will be recorded on PARIS. For example, if a high-risk patient attends A&E, this will be flagged. There will be an escalation process for concerns. PARIS “plus” will allow read-only permissions for other agencies when appropriate.

The implementation of PARIS began in December 2013 with a view to implementation across the trust within two years. Mental health service staff were scheduled to be trained on the use of PARIS in June 2014. The first mental health teams are scheduled to start using PARIS in August and October 2014.

We were told that the trust has rolled out a programme of clinical risk formulation training.

## **16.3 Inpatient model**

We were told by the trust that there are now more assertive links with the CMHTs, and that the wards now have discharge standards. We were given a draft of the new discharge standards dated May 2013.

## **16.4 Links with the police and forensic services**

The trust website stated in April 2014 that the “Tameside street triage pilot” was launched on 31 March and would operate between 14:00 and midnight, seven days a week for five weeks. The pilot involved the trust’s mental health services and Tameside police. The purpose of the project was described as:

“... to provide advice and support to police officers attending any incident that potentially involves a person with a mental illness”;

and

“... to improve relationships between health services and the police”.

We were told that the number of MHA 136 sections had reduced.

We were told that the MDO/criminal justice team is very engaged and that there are good connections with the police and probation service. Steps are being taken to explore whether the team could be more engaged with the care coordinators, and act essentially as a forensic community service.

## **16.5 Physical health**

The trust has implemented a new physical health programme. We were told that 737 staff had undertaken physical health courses in the last five years.

## **16.6 Divisional integrated governance groups (DIGGs)**

The trust action plan allocates the responsibility for monitoring progress against a number of areas to the North and South DIGGS. These are:

- risk assessment;
- management of high-risk service users who are difficult to engage;
- medicine management;
- substance misuse;
- links with forensic services; and
- clinical and managerial supervision.

The trust gave us extracts of minutes of the Northern DIGG dated between March and September 2013. The minutes illustrate that the case of Mr E was being discussed at the meeting and updates given. The extracts do not, however, illustrate progress against the broader aspects of the action plan, e.g., medicines’ management and MAPPA.

The minutes for 6 February 2013 state that:

“The group discussed the idea that this [clinical risk register for high-risk patients] could be [a] trust sub-MAPPA register and would show the services are coordinated and provide evidence should any findings be disrupted. The emphasis was placed on joined services and an ability to ensure that all efforts could possibly be made for such [high risk] in the community”.

Those for 5 June declare an undertaking:

“to look at re-launching a CPA group to get some energy and interest from service lines. We need to re-own this process”.

The extracts we have been given demonstrate that issues were being discussed but do not outline the extent of progress made.

## **16.7 Analysis**

The trust has significantly overhauled mental health services, and has a strategic plan, changes for which are scheduled to continue into 2015. We accept that progress with the action plan runs in parallel with the restructure, and that consequently there are areas that the trust needs to work on. We were not given evidence of progress against all of the action plan recommendations (for example recommendation 3<sup>1</sup> and recommendation 5<sup>2</sup>), rather we were told of what was planned. As a result in turn, we recommend that progress against the action plan be reviewed again at a later stage once the new service structure is further embedded.

## **16.8 Finding**

The trust’s progress against the action plan is continuous and scheduled for completion in March 2015.

---

<sup>1</sup> “Clinical team leaders should have overall responsibility for ensuring that risk assessments are regularly updated, that care plans address the identified risks, and that if the risks are not manageable, for whatever reason, then this is escalated to the appropriate authority”.

<sup>2</sup> “The Trust, as a priority, should consider how best to develop more sophisticated approaches to ensuring concordant therapy. In particular, encouraging compliance and monitoring. We also recommend that, through the process of clinical supervision, the competency of supervisees in medication concordance is assessed and training needs are identified. In particular, supervision should focus on the need for medication, i.e., its specific indication should be understood by the patient and the care team. Also, its priority in the overall treatment plan should be explicit, as should be the contingencies in the case of non-compliance”.

## **16.9 Recommendation**

There has been a significant overhaul of mental health services at the trust since late 2010 and changes are continuing. The AOT no longer exists and the service transformation is scheduled for completion in March 2015. As a result of this we anticipate that it will take time before the new model and ways of working are fully embedded at the trust.

We recommend that the trust's progress with the action plan be audited within 12 months and used to examine the extent to which changes have become effectively embedded within the trust's structure and mental health services.

### Biographies

#### **Kathryn Hyde-Bales**

Kathryn is a senior consultant at Verita with a background in investigations and regulation. She previously worked at the Care Quality Commission (CQC) where she managed the provision of analytical support to stand-alone projects and regional teams covering the NHS, independent and social care sectors. At Verita she has worked on numerous mental health homicides, reviews of safety at homes providing care for the elderly, and on clearing a backlog of complaints at a Midlands trust. Kathryn was a member of the team providing oversight of the three main NHS investigations into allegations about sexual abuse by Jimmy Savile.

#### **Chris Brougham**

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

#### **Peter Jefferys**

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

### Trust internal investigation report recommendations

#### Recommendation 1

Changes in mental health and risk presentation should be reviewed and evaluated by the care coordinator with care plans and risk assessment updated and communicated accordingly to all involved in the care delivery.

#### Recommendation 2

Risk assessment should not be an end in itself, but inform the management plan, which should be regularly updated by significant clinical events. Therefore, both risk assessment and formulation need to be dynamic, comprehensive, and readily accessible by all the MDT<sup>1</sup>. This needs to be addressed through an appropriate training strategy and regular and supportive clinical and managerial supervision.

#### Recommendation 3

Clinical team leaders should have overall responsibility for ensuring that risk assessments are regularly updated, that care plans address the identified risks, and that if the risks are not manageable, for whatever reason, then this is escalated to the appropriate authority.

#### Recommendation 4

- A) Patients who are identified as difficult to engage in treatment should be comprehensively assessed there should be a full formulation of need and detailed care plan.
- B) The role of care coordinator is pivotal in the delivery of continuity of care. As such there must be sufficient resources, support and development of skills to ensure safe deliver of the care plan by the care coordinator. The patient should not be allowed to cross a care boundary e.g. discharge from inpatient care to community until and unless the care coordinator is content that the care plan is sufficient to manage the risks.

#### Recommendation 5

The Trust, as a priority, should consider how best to develop more sophisticated approaches to ensuring concordant therapy. In particular, encouraging compliance and monitoring. We also recommend that through the process of clinical supervision, that competency of supervisees in medication concordance is assessed and training needs are identified. In particular, supervision should focus on the need

---

<sup>1</sup> Multidisciplinary team

for medication i.e. its specific indication should be understood by the patient and the care team. Also, its priority in the overall treatment plan should be explicit, as should be the contingencies in the case of non compliance.

### **Recommendation 6**

The review panel recommend that the Trust review and evaluate current substance misuse strategies and policies (both drug and alcohol), and take account of the issues arising from this review. In particular, the review should also include a training needs analysis in respect of clinical management of substance misuse, and target training and broader education to provide the knowledge, skills and confidence to meet the needs of service users with a dual diagnosis and complex problems. The consideration of the benefits of clinical supervision as a means of problem-solving, goal-setting and skills development should be included in the proposed training needs analysis review.

### **Recommendation 7**

The Trust should further explore links with forensic services, in particular access to forensic assessments, and opportunities to discuss risk concerns and how to link with MAPPA forums in order to improve safety management plans. The Trust should also ensure wide awareness of the MDO's capacity to discuss cases that cause significant concerns re harm to others and provide advice on public protection.

### **Recommendation 8**

Health promotion, holistic and physical health care and wellbeing including, diet, smoking and physical health care checks should be the subject of staff development programmes and a focus of clinical and managerial supervision.

### **Recommendation 9**

- A)** Inpatient care should be seen as an opportunity to re-evaluate the patient, the formulation and risk assessment. Where there are different clinicians, especially consultants, then there should be an explicit expectation with regard to joint care planning and information sharing.
- B)** Difficult to manage patients risk becoming unpopular on the inpatient unit, and there is a need for strong leadership to overcome alienation and resist calls for a premature discharge.

### **Recommendation 10**

We urge that these findings be discussed with the senior police managers, and that the Trust and Police Services review the current protocols for liaison, and explore joint training opportunities.

### **Recommendation 11**

The investigation team recommends that clinical supervision includes close scrutiny of the supervisees care coordination, risk assessment, practice, and documentation. There should be a focus on comprehensiveness of documentation and a review to identify whether the clinical record sufficiently reflects the necessary information intended to meet the identified needs of the individual.

### **Recommendation 12**

- A)** The investigation team recommends that the Trust should further develop its managerial and clinical supervision policy and procedures, to facilitate supervision being utilised to provide assurance to the Trust Board that patient care is of the required standard.
- B)** The supervision process should enable support, monitoring, and development at every level, to ensure clinical practice reflects the requirements of the clinician's professional duties, and of prescribed changes in practice, such as the recommendations of this and other serious untoward incident reports.
- C)** Staff should be reminded of their own professional accountability for accessing clinical supervision.

### **Recommendation 13**

Workforce, Training and Development – The Panel recommend that the Trust should take account of the training, professional development and support needs and concerns arising from this review and re-evaluate the training and development priorities.

## Trust action plan

**Pennine Care NHS Foundation Trust****ACTION PLAN – Mr E**

Area of concern	Recommendation supporting the action	Action point	Monitoring/ responsible forums	Completion date	Evidence of action point
<b>A) Risk Assessment</b>	Rec 1 Rec 2 Rec 3	<ol style="list-style-type: none"> <li>1) Risk assessment tool/paperwork to be updated in line with the PARIS patient record developments across the Trust.</li> <li>2) A review of the current CPA policy to be conducted to introduce a CPA level that will be supported by a Governance tool for robust communication in relation to the level of risk to others/increased danger.</li> <li>3) Risk assessment/formulation training to be rolled out across the organisation.</li> <li>4) Development of MDT reviews for service users who present with increased risk to others. This will be in line with the CPA process.</li> </ol>	<ul style="list-style-type: none"> <li>• North &amp; South Divisional Integrated Governance Groups (DIGGs)</li> <li>• Trust wide Community Services Group (Tier 4)</li> <li>• North Division Community Strategy Group (CSG)</li> <li>• CPA Group and sub group</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	

			<ul style="list-style-type: none"> <li>Educational Governance Group (EGG)</li> </ul>		
<b>B) Management of high risk Service Users who are difficult to engage</b>	Rec 1 Rec 2 Rec 3 Rec 4 Rec 4 (a) Rec 4 (b)	<ol style="list-style-type: none"> <li>1) Development of MDT reviews for service users who present with increased risk to others. This will be in line with the CPA process.</li> <li>2) A review of the current CPA policy to be conducted to introduce a CPA level that will be supported by a Governance tool for robust communication in relation to the level of risk to others/increased danger.</li> <li>3) The use of zoning across the community teams – as a tool for communicating risk.</li> <li>4) Closer working with CJMH service for those clients identified via the CPA process as being higher risk.</li> <li>5) Inhouse training programme to be developed and rolled out across community services, in line with the community Transformation Project. Specific training required for “dealing with dangerous clients”.</li> </ol>	<ul style="list-style-type: none"> <li>North &amp; South Divisional Integrated Governance Groups (DIGGs)</li> <li>Trust wide Community Service Group (Tier 4)</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	
<b>C) Medicine Management</b>	Rec 4 (a) Rec 4 (b) Rec 5	<ol style="list-style-type: none"> <li>1) Development of MDT reviews for service users who present with increased risk of non concordance/increased risk/increased level of danger. These reviews to include pharmacy staff.</li> <li>2) The use of “Community Treatment Orders” in relation to non concordance being a trigger to the higher risk level of CPA.</li> <li>3) The Community Mental Health Service Transformation Project to map out training needs for the newly configured services (project running 1.4.13 → 31.3.15,</li> </ol>	<ul style="list-style-type: none"> <li>North &amp; South Divisional Integrated Governance Groups (DIGGs)</li> <li>Trust wide Community Service Group (Tier 4)</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	

<b>D)</b> <b>Substance Misuse</b>	Rec 1 Rec 2 Rec 3 Rec 4 (a) Rec 4 (b) Rec 5 Rec 6	<ol style="list-style-type: none"> <li>1) The Community Mental Health transformation project to consider the links with substance misuse services.</li> <li>2) Strategic development of services for dual diagnosis clients to be reviewed in line with the Transformation Project.</li> <li>3) The transformation project to include SMS training in their training needs analysis as they roll out the project.</li> <li>4) Use of drugs on the Inpatient Units to be discussed and plans agreed at the Acute Care Forum.</li> <li>5) Liaison with Police/A&amp;E/Housing to be increased as services move to locality based business units – focused on the townships.</li> <li>6) Physical health in Mental Health to be part of a training programme. This should be completed prior to the Transformation Project, in line with CQUIN target dates.</li> <li>7) Suicide Prevention/Self Harm policies to be reviewed in line with the Transformation Project.</li> </ol>	<ul style="list-style-type: none"> <li>• North &amp; South Division Integrated Governance Groups (DIGGs)</li> <li>• Trust wide Community Services Group (Tier 4)</li> <li>• North Division Community Strategy Group (CSG)</li> <li>• CPA Group and sub group</li> <li>• Educational Governance Group (EGG)</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	
<b>E)</b> <b>Links with Forensic Services</b>	Rec 1 Rec 2 Rec 3 Rec 4 (a) Rec 4 (b) Rec 7	<ol style="list-style-type: none"> <li>1) Review of the CPA policy/processes will ensure greater links to MAPPA for the development of safety management plans.</li> <li>2) In-house training programme to be rolled out in line with the Transformation Policy – specific training “dealing with dangerous clients”,</li> <li>3) Review of the P.I.C.U. pathway to be undertaken.</li> <li>4) Review of the forensic assessment referral route/timescales to be conducted.</li> </ol>	<ul style="list-style-type: none"> <li>• North &amp; South Divisional Integrated Governance Groups (DIGGs)</li> <li>• Trust wide Community Service Group (Tier 4)</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	
<b>F)</b>	Rec 8	<ol style="list-style-type: none"> <li>1) Physical health matters training</li> <li>2) Physical health CQUIN target</li> <li>3) Review of Physical Health policy</li> </ol>	<ul style="list-style-type: none"> <li>• Clinical Lead – Service Improvement, Head of Audit and Effectiveness</li> </ul>	March 2014 (in line with	

<b>Physical Health care/health promotion</b>				CQUIN target)	
<b>G) Inpatient care for difficult to manage clients</b>	Rec 1 Rec 2 Rec 3 Rec 4 (a) Rec 4 (b) Rec 5 Rec 6 Rec 7	1) Discharge planning standards to be set and agreed across inpatient/community services 2) Formal CPA meetings to be held for all detained patients prior to discharge, this will be audited 3) Use of Community Treatment Orders for clients presenting with possible disengagement/non concordance	<ul style="list-style-type: none"> <li>Task &amp; Finish Group</li> </ul>	February 2014	
<b>H) Police Liaison</b>	Rec 10	1) Pilot project from Oldham to be considered in all other Boroughs – Street Triage.	<ul style="list-style-type: none"> <li>Lead: Acute Service Line Manager /Service Director</li> </ul>	August 2014	
<b>I) Clinical and Managerial supervision</b>	Rec 1 Rec 2 Rec 3 Rec 4 (a) Rec 4 (b) Rec 5 Rec 11 Rec 12 (a) Rec 12 (b) Rec 12 (c)	1) Review of the Policy. 2) Audit to be undertaken. 3) Results to be actioned via DIGGS.	<ul style="list-style-type: none"> <li>Audit team</li> <li>Divisional Integrated Governance Groups (DIGGs).</li> </ul>	April 2014	

<b>J)</b> <b>Training</b>	Rec 1 Rec 2 Rec 3 Rec 4 (a) Rec 4 (b) Rec 6 Rec 7 Rec 8 Rec 9 (a) Rec 9 (b) Rec 12 (a) Rec 12 (b) Rec 12 (c)	1) The Community Transformation Project to map out training needs for the newly configured services. Project running 1.4.14 → 31.3.15. 2) Training needs analysis (TNA) from the Transformation Project to be processed via EGG. 3) RCA panel recommend the following are considered in the TNA <ul style="list-style-type: none"> <li>• Modern approaches to prescribing</li> <li>• Therapeutic innovation</li> <li>• Personality Disorder</li> <li>• Conflict resolution</li> <li>• Substance misuse</li> <li>• Risk assessment/formulation</li> </ul>	<ul style="list-style-type: none"> <li>• Divisional Integrated Governance Groups (DIGGs)</li> <li>• Educational Governance Group (EGG)</li> </ul>	31.3.15 (in line with the Transformation of Community Mental Health Services project)	
------------------------------	--	--	---	---	--

### Documents reviewed

#### Medical records

- Mr E's medical and nursing records

#### Policies and procedures

- *Care Programme Approach policy (2010 and 2012 versions)*
- *Clinical Risk Assessment and Management policy (2010 and 2013 versions)*
- *Non-access to a client's home/non-attendance at clinic appointments policy*
- *Dual diagnosis strategy (2010 and 2012 versions)*
- *Incident reporting, management and investigation policy (2010 and 2012 versions)*
- *Safeguarding adults policy (2009 and 2013 versions)*
- *Trust information sharing protocols*

#### Internal report

- Initial investigation report
- SUI review report, December 2012
- SUI interview transcripts
- Action plan
- Details of the trust's progress against the action plan

#### Other

- Mr E's forensic records
- MAPPA information
- *The investigation of serious patient safety incidents in mental health services (2008)*. NPSA.
- *Being open guidance: communicating patient safety incidents with patients, their families and carers (2009)*. NPSA.
- Correspondence between health care professionals