



An independent investigation into the care and treatment of a mental health service user Mr K in Suffolk

September 2019

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Niche Health and Social Care Consulting Ltd is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive summary

- 1.1 NHS England, Midlands and East commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr K. Niche is a consultancy company specialising in patient safety investigations and reviews.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework¹ (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.² The terms of reference for this investigation are given in full in Appendix A.
- 1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.

Mental health history

- 1.5 Mr K's care and treatment was provided by the Community Mental Health Team (CMHT) of Norfolk and Suffolk NHS Foundation Trust ('the Trust' or NSFT from herein), under the Care Programme Approach (CPA) via outpatients' appointments provided by the consultant psychiatrist as lead professional.
- 1.6 Mr K first had contact with mental health services in late 2005 following a referral from a substance misuse service. He had originally been seen by the then Trust community drug service from 2001, as he was noted as having a heroin addiction.
- 1.7 By the age of 16 he was using cannabis and other substances and had begun to express paranoid ideas. He served a prison sentence for stabbing his friend, which Mr K claims occurred because he mistook him for a burglar.
- 1.8 Following two incidents of aggression in December 2005 and January 2006 he was assessed by a forensic psychiatrist. He had attacked his neighbour's door with a shovel, as a result of thoughts that his neighbours were deliberately making noises to upset him. He is reported to have made threats to kill the occupants.

¹ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

² Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

- 1.9 Mr K reported feeling that there was a conspiracy to persecute him, and also he had low mood and was hearing voices telling him to harm people. These symptoms were understood to be associated with anxiety, obsessive compulsive and emotionally unstable personality traits related to paranoia associated with substance misuse, opiate dependency and isolation. They were not deemed psychotic in origin.
- 1.10 Mr K was admitted to an acute inpatient mental health ward in September 2008 for four weeks. He was admitted following a serious overdose with reported low mood and hearing voices. He was noted to have suffered a deterioration in his mental health and Mr K described hearing voices putting him down.
- 1.11 He was discharged into the care of the community mental health team (CMHT) in October 2008 with a care coordinator (CCO) and consultant psychiatrist. On discharge it was noted that his diagnosis was not confirmed and it was concluded that Mr K's beliefs were not considered to be definitely psychotic in nature.
- 1.12 Mr K remained under the care of the CMHT, the then Trust substance misuse service, Housing Support Officer and his GP with relatively few concerns.
- 1.13 A trial of clozapine³ was proposed in 2011 but was not implemented due to concerns raised about his weight and type 2 diabetes.
- 1.14 Mr K was transferred from the Trust drug treatment services to a different substance misuse service on 1 April 2011. This transfer related to provider arrangements. His records on transfer state that he was stable on his prescription of methadone⁴ having reduced the dose from 100 ml per day to 7 ml per day over the previous 12 months.
- 1.15 In 2012 his care was adapted to provide consultant support only. It is noted by his substance misuse worker that Mr K was upset about this.
- 1.16 During 2012 and 2013, he was seen monthly by the consultant psychiatrist, and remained under the care of community drug services, GP and housing provider. There are reports of self-management of methadone use and infrequent but short lived heroin use, but otherwise his contact with services was relatively uneventful.

Offence

- 1.17 At 2.50 am on the morning of 13 June 2013, the police received a report of a stabbing at the flat of Mr K. On arrival the police and paramedics found a man (Russell, who was a friend of Mr K's) with stab wounds. He was taken to

³ Clozapine is prescribed to relieve the symptoms of psychosis. <https://patient.info/medicine/clozapine-clozaril-denzapine-zaponex>

⁴ Methadone is a drug that is similar to heroin, and is prescribed as a substitute. <https://patient.info/health/methadone-replacement-for-heroin>

hospital where he later died. The partner of Mr K also sustained stab wounds to her leg but was later discharged.

- 1.18 Mr K was immediately admitted to the local acute hospital after a reported overdose of methadone. He was assessed and declared medically fit the following day. Mr K was assessed under the Mental Health Act⁵ (MHA) and detained under Section 2 MHA⁶ and subsequently transferred to a secure mental health unit.

Recommendations

- 1.19 In June 2013 an internal investigation was commissioned by Public Health⁷ in Suffolk. Since July 2017 Public Health and Protection sits under the Directorate of Health, Wellbeing and Children's Services at Suffolk County Council. A 'stop the clock' request was made by the report authors to commissioners after Suffolk Constabulary requested that the internal investigation be suspended while the criminal investigation process was underway. The investigation was started again in October 2013, after agreement from the police was received. The final internal investigation report made 17 recommendations across the differing providers related to their findings in the investigation.
- 1.20 The evidence for implementation of the action plans across providers has been reviewed. It became evident that the implementation of the action plan had been monitored individually by each service provider, but that there had been no formal oversight of the overall report findings and action plan. Also, the internal investigation report had not been shared with the family of the victim or perpetrator.

It is on this basis that the following six recommendations are made.

⁵ *The provisions of this Act shall have effect with respect to the reception, care and treatment of mentally disordered patients, the management of their property and other related matter.* <http://www.legislation.gov.uk/ukpga/1983/20/contents>

⁶ *A patient may be admitted to a hospital and detained there for up to 28 days for assessment and treatment.* <http://www.legislation.gov.uk/ukpga/1983/20/section/2>

⁷ <https://www.suffolk.gov.uk/adult-social-care-and-health/>

Recommendation 1

The Trust should utilise the joint information sharing agreement with Suffolk Constabulary to clarify patients' forensic history, within the bounds of the accepted criteria.

Recommendation 2

Public Health Suffolk should ensure that if a multi-agency investigation is commissioned there is a mechanism to oversee the implementation of the action plan and the involvement of family and carers; serious incident investigation policies should be updated to include this requirement.

Recommendation 3

The joint partnership should complete a formal audit of the existing multi-agency Dual Diagnosis guidance and protocol and ensure it is fit for purpose and implemented across the agencies.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

Recommendation 4:

NSFT should evidence its improvement programme for care planning and risk assessment quality and compliance.

Recommendation 5:

The 'Joint Working Protocol: Identifying the Lead Agency when working in Partnership' should be agreed, signed off and implemented by all partner agencies, within six months. Implementation should then be monitored.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

Recommendation 6:

Public Health Suffolk should undertake an assurance audit of the implementation of the action plan

2 Independent investigation

Approach to the investigation

- 2.1 The independent investigation follows the NHS England Serious Incident Framework⁸ (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.⁹ The terms of reference for this investigation are given in full in Appendix A.
- 2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 2.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.
- 2.4 The investigation was carried out by Carol Rooney for Niche, with expert advice provided by Dr Mark Potter, consultant psychiatrist.
- 2.5 The investigation team will be referred to in the first person plural in the report.
- 2.6 The report was peer reviewed by Nick Moor, Partner, Niche.
- 2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.¹⁰
- 2.8 A list of information accessed is at Appendix B.
- 2.9 Due to the primary focus of this investigation being the response to the internal investigation findings and action plan, we did not interview clinical staff, but focussed our efforts on obtaining information and evidence of the implementation of the action plans.
- 2.10 The internal investigation report was written by the (then) substance misuse provider Crime Reduction Initiative (CRI) and a multi-agency action plan was produced. We have reviewed the action plan responses from the agencies concerned. A meeting was held in August 2017 with the relevant service

⁸ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

⁹ Department of Health Guidance ECHR Article 2: investigations into mental health incidents <https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents>

¹⁰ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

providers to discuss the progress of each individual service with regard to the action plan.

- 2.11 A draft of this independent investigation report was shared with the Trust and partner agencies. This provided opportunity for factual accuracy review and comment.

Contact with the victim's family

- 2.12 We have spoken to the victim's mother by phone, met with a member of the victim's family, and met with his partner. They have all indicated that they wish the victim to be referred by his first name, Russell, where he is referenced in the report. The family particularly wished to know how Mr K's previous history of violence with a bladed weapon was incorporated into his risk assessment and management.
- 2.13 We offered the opportunity to meet with us prior to publication of the report. The lead author and NHSE commissioner met with members of Russell's family in June 2018, and talked through the findings of the report. They expressed the hope that lessons would be learned that could help prevent other families from going through what they have experienced.

Contact with the perpetrator's family

- 2.14 We have met with Mr K's sister, who has provided a family perspective on Mr K's care. Mr K's mother did not initially want to communicate directly with the investigation and the family had agreed that his sister would be the family point of contact.
- 2.15 We offered the opportunity to meet with us prior to publication of the report, and met with Mr K's mother and stepfather in June 2018. They told us of their worries about Mr K over the years, and how they are pleased about how he is being cared for now.
- 2.16 Mr K's partner was contacted by NHS England and later by us, but we did not receive a response.

Contact with Mr K

- 2.17 Dr Mark Potter met with Mr K and his current psychiatrist as part of the investigation. Mr K had no recall of any concerns about his care prior to the homicide, and this included having no complaints about the change to one professional as care coordinator.
- 2.18 Notably Mr K now has a definite diagnosis of schizophrenia and is being treated with clozapine.
- 2.19 We met with Mr K prior to publication of the report, to share the findings.

Structure of the report

- 2.20 Section 3 describes Mr K's background, and Section 4 describes the care and treatment provided to Mr K.
- 2.21 Section 5 examines the issues arising from the care and treatment provided to Mr K and includes comment and analysis and a review of the internal investigation.
- 2.22 Section 6 reports on the progress made in addressing the organisational and operational matters identified.
- 2.23 Section 7 sets out our overall analysis and recommendations.

3 Background of Mr K

Childhood and family background

- 3.1 Mr K was 38 at the time of the homicide, and was born and raised in Ipswich. His schooling was interrupted by an ear operation at the age of 6 and it was around this time that his parents separated and his father lost his business. He has one half-sister. There are records which report that Mr K was physically abused by his father, often did not receive presents for birthdays and was expected to do all the housework.
- 3.2 He began getting into trouble at school from the age of 8 and by the time he was 11 he had received 6 police cautions. He was regularly suspended from school for abusive behaviour and swearing at teachers. A report in 2006 describes how on one occasion he arrived at school with bruises on his face and when the teachers learned about this he was transferred to Belstead Road Boys Home where he said he was bullied.
- 3.3 He was eventually sent back to his father's address. He described a reduction in the physical abuse due to regular visits by a social worker.
- 3.4 He left school without any qualifications. Mr K worked as an under pinner for over two years, and although he has had some odd jobs, he has been mostly unemployed since then.

Relationships

- 3.5 Mr K's first use of heroin occurred in 2001 during a relationship break down. He has had a number of heterosexual relationships and has no children. There is a report from a housing support worker that Mr K reported being the victim of domestic abuse in 2012. It is not known what occurred as a result of this although it is recorded that he was offered help.
- 3.6 At the time of the homicide he had been with his partner for eight years although this was reported to be a volatile relationship at times.

Forensic history

- 3.7 By the time Mr K was 11 years old he had received six police cautions, including one for smashing the windows in a St John's ambulance centre. In 1991 at the age of 16 he received a prison sentence for stabbing a friend whom Mr K claimed he had mistaken for a burglar. He received a sentence of nine months of which he served four.
- 3.8 He was referred to the Suffolk forensic service in February 2006. The consultant forensic psychiatrist's report of the assessment does not give detail of his forensic history.

3.9 Mr K's family state that he received a prison sentence for stabbing as an adult, and in a risk assessment written in January 2012 there is a mention of a conviction for assault in 2004, when he 'stabbed a friend who entered his property, and may have been under the influence of illegal drugs at the time'.

3.10 There is no clear description or record of this offence in the Trust clinical records. It is variously referred to as outlined below:

- In an assessment by the community home treatment team on 15 November 2005: 'prison sentence for assault two years ago, attacked a friend with a blade'.
- In the forensic assessment of 7 February 2006: 'living alone since aged 16, received a prison sentence around this time following conviction for assault, apparently he attacked a friend with a bladed weapon'.
- At a multi-agency meeting on 21 March 2006 it is noted that 'his probation order will run until March 2007. [Probation officer] noted that [Mr K] is not taking responsibility for his offence or his behaviour'.
- In a psychiatric report for court dated 29 June 2006 his offences are noted as 'from age 11 onwards various convictions for criminal damage and theft, at age 18 he had an argument with his father and hit him. His father hit him with a hammer that rendered him unconscious for a few seconds. When he left the house a man in a car laughed at him and [Mr K] pushed him through a window. This accumulation of crimes led to a prison sentence of four to six months. Later on in his teens when he was on heroin another addict stole from him and he attacked him with a bladed weapon which led to another prison sentence of nine months reduced to four months for good behaviour. He said that was his last sentence'.
- After an outpatient appointment on 7 November 2008 Mr K's consultant psychiatrist noted he had been 'imprisoned a couple of years ago for a serious assault using a blade, although from the account that I have seen, the attack was not necessarily based on paranoia. Other behaviours including damage to property have perhaps been related to paranoid ideation'.
- FACE¹¹ risk assessment conducted by the consultant psychiatrist on 21 June 2012 'served prison sentence for assault with a knife in 2004'.

3.11 It appears that there is some conflation in the records of the assault with a bladed weapon aged 16, and an assault with a bladed weapon as an adult, possibly around 2004 (when he would have been aged 29). We have attempted to gain factual information about Mr K's forensic history from Suffolk Constabulary but this request was refused. What is clear is that substance misuse and mental health services did not have an accurate record

¹¹ FACE assessment tools are nationally-accredited by the Department of Health and used throughout the UK & Ireland by NHS, social care and independent sector organisations. <http://www.face.eu.com/solutions/assessment-tools>

of his offending history. There is however an information sharing agreement between the Trust and Suffolk Constabulary, that has been in place since 2014.

Recommendation 1:

The Trust should utilise the joint information sharing agreement with Suffolk Constabulary to clarify patients' forensic history, within the bounds of the accepted criteria.

4 Care and treatment of Mr K

- 4.1 Mr K first had contact with mental health services in late 2005 following a referral from the substance misuse service. He was assessed in November 2005 by the crisis resolution home treatment team, and referred for a psychiatric assessment. He had originally been seen by the then Trust community drug services who had assisted him with his methadone prescription from 2001, as he was noted as having a heroin addiction.
- 4.2 From 2006 to 2008 Mr K's care and treatment was provided by then Suffolk Mental Health Partnership NHS Trust (from 2011, Norfolk and Suffolk NHS Foundation Trust), under CPA. Following two aggressive incidents in December 2005 and January 2006 he was assessed by a forensic psychiatrist and later seen by an independent psychiatrist for a court report. He is reported to have made threats to kill his neighbours, and had attacked their front door with a spade, breaking it down. These incidents occurred as a result of him having thoughts that his neighbours were deliberately making noises to upset him.
- 4.3 The forensic psychiatrist noted in February 2006 that that he considered Mr K's symptoms were associated with anxiety, obsessive compulsive and emotionally unstable personality traits accompanied by paranoia associated with substance misuse, opiate dependency and isolation. These symptoms were not deemed to be psychotic in origin. The independent psychiatrist's opinion in June 2006 was that Mr K was in the early stages of a paranoid schizophrenia, and was also suffering from a delusional disorder.
- 4.4 Mr K was treated as an outpatient by the Trust's Suffolk Forensic service from 2006 to 2008, when he was referred back to Ipswich community mental health team (CMHT). He received psychological input from the team psychologist, although there is no detail of this. Mr K was prescribed olanzapine¹² to treat psychotic symptoms, and mirtazapine¹³ for depression. He attended appointments but did not always take medication regularly, although he restarted when advised to do so by the forensic psychiatrist. It was noted in August 2008 that his paranoid thoughts returned after he stopped taking both of the prescribed medications, and then had thoughts that others were out to kill him. He reported taking a knife out with the intention of killing someone but 'deflected these thoughts'.
- 4.5 Mr K was admitted to a mental health inpatient ward at St Clements Hospital Ipswich in September 2008 for four weeks. He had taken a serious overdose and he reported low mood and hearing voices. He was noted to have suffered a deterioration in his mental health and Mr K described hearing voices and whispering voices putting him down.

¹² Olanzapine belongs to a group of medicines called antipsychotics. It is prescribed to relieve the symptoms of schizophrenia. <https://patient.info/medicine/olanzapine-arkolamyl-zalasta-zyprexa>

¹³ Mirtazapine works by increasing the amount of noradrenaline and serotonin available in the brain. This can help ease the symptoms of depression. <https://patient.info/medicine/mirtazapine-for-depression-zisprin-soltab>.

- 4.6 He was discharged into the care of the Crisis Resolution Home Treatment Team (CRHT) and then the CMHT in October 2008 with a care coordinator (CCO) and consultant psychiatrist. Mr K remained under the care of the CMHT, Trust substance misuse services and his GP with relatively few concerns.
- 4.7 The initial care plan included treatment with medication, mental health monitoring and support to develop activities outside the home. This element of the care plan was unsuccessful however, as Mr K was too anxious to leave his accommodation by himself.
- 4.8 It was also reported at this time that Mr K was noted to be over reliant on the hostel staff and 'would benefit from increased independence'. The internal investigation report notes that the implication from the records was that the communal living situation was unhelpful given Mr K's hyper-vigilance and anxiety about other people.
- 4.9 His diagnosis was a source of debate. Diagnoses of anxiety with episodes of psychosis were suggested. He was also differentially diagnosed as demonstrating elements of 'obsessive compulsive' and 'emotionally unstable' personality disorder.
- 4.10 A trial of clozapine was proposed in 2011 but was not implemented due to concerns raised about his weight and type 2 diabetes. The possibility of a trial of clozapine was raised again at his most recent review in May 2013; this time with the proviso that the Community Home Treatment Team (Drug / Physical Health Care service) be included to address monitoring of physical health through the process of titration.
- 4.11 Mr K was transferred to the substance misuse service 'Crime Reduction Initiative' (CRI)¹⁴ from the Trust service on 1 April 2011. This transfer related to a change in provider arrangements, which resulted in the Trust no longer providing this service. His records on transfer state that he was stable on his prescription of methadone having reduced the dose from 100 ml per day to 7 ml per day over the previous 12 months.
- 4.12 In 2012 his care was adapted to provide consultant support only, without discussion with other services who were involved with Mr K. It is noted by the substance misuse worker that Mr K was upset about this. Prior to this he had been receiving input from both the CCO and the consultant psychiatrist. In the meeting we had with him as part of this independent investigation, Mr K expressed no concerns about this change.
- 4.13 At the time of the homicide, he was being seen monthly by the consultant psychiatrist, and remained under the care of CRI and his GP, with support from the housing related provider. There are reports of self-management of methadone use, infrequent but short lived heroin use but otherwise his contact with services was relatively uneventful.

¹⁴ (Crime Reduction Initiative, now named Change, Grow, Live)

- 4.14 The internal report provides evidence from the electronic record system (ePEX) that regular review took place. The Trust electronic records system however indicates that there was not a systematic approach to multi-agency working noting that the last multi-agency meeting was on 5 December 2011, although there is evidence of individual and partial agency reviews up until 12 April 2013 with his consultant psychiatrist.
- 4.15 In May 2013 Mr K tentatively agreed to the psychiatrist's suggestion of a trial of clozapine, and a reducing regime of aripiprazole ¹⁵was agreed. A telephone consultation with Mr K was planned for 6 June, which he did not attend. A further outpatient appointment was made for August 2013. The Trust was informed that he had been arrested on 13 June 2013.

Arising issues, comment and analysis

- 4.16 As highlighted in the internal investigation report, Mr K's care should have been managed under the dual diagnosis policy, with a lead agency agreed. This should have ensured that information about his progress, mental state and use of illicit substances was shared across the partners. We agree with the findings of the internal investigation report, and have therefore not repeated them, but have listed some further observations below.
- 4.17 There is some evidence that Mr K's mother and partner were involved in mental health team meetings and discussions about Mr K's progress. His partner attended the last outpatient appointment in May 2013, to express her concern that Mr K had appeared paranoid and agitated one month previously and had heard his father's voice, believing he was present in the house. There were no references to carers' assessments for his partner or his mother.
- 4.18 His chronic anxiety was still present in May 2013 and he continued to report hearing noises from neighbours and feeling that he is being watched. The subsequent letter to the GP reported that there were no overt psychotic features, but that Mr K had agreed to a trial of clozapine. In April 2013 the outpatient letter to the GP again noted the uncertainty about his diagnosis, and referred to Mr K's 'reported psychotic symptoms', which were not present at the outpatient appointment.
- 4.19 In spite of this reported lack of clarity, he was prescribed medication and treated as though he did have a diagnosis of psychotic disorder. However we consider there was sufficient evidence to make a firm diagnosis of a psychotic disorder.
- 4.20 There are regular reports in clinical notes of his hearing voices to harm others (variously his mother, partner and others unspecified) which vary from hitting people to killing people. He also reported voices telling him to harm or kill

¹⁵ Aripiprazole is an antipsychotic medication, prescribed to relieve the symptoms of schizophrenia.
<https://patient.info/medicine/aripiprazole-abilify>

himself. His coping mechanisms for these were to stay indoors as much as possible.

- 4.21 We found a lack of detailed assessment of his risk of harm to himself and to others, and a reliance on medication as the only intervention by mental health services from 2012 onwards. The risk assessment of his risk of harm to others was not based on accurate information. See Recommendation 1.
- 4.22 Outpatient contacts were not routinely entered as clinical notes by the outpatient psychiatrist, and the detail of what was discussed and decided is contained in the letter to the GP only. This means that the ePEX record did not provide a continuous record of clinical contacts. We have been made aware that the health records policy was adjusted in January 2016 to clarify how a consultant's outpatient letter may be captured as a clinical entry.

5 Internal report

- 5.1 The internal report was completed by the substance misuse service CRI and was written as a multi-agency report. The report reviewed the care provided by multiple agencies, and a multi-agency review panel were involved in quality checks and sign off. The report was 'signed off' and accepted by NSFT, CRI and Ipswich Housing Action Group (IHAG). There is a detailed timeline of the milestones of the investigation, with explanation for any delays and for decisions made during the process.
- 5.2 The report provides a detailed review of Mr K's care. An amalgamated chronology of contacts and care given by all agencies is provided. The terms of reference for the internal investigation were:
- To review and investigate the circumstances giving rise to this incident
 - To review and assess the care and treatment of the client prior to the murder and assault
 - To assess compliance with protocols, policies and procedures in relation to the care provided
 - To identify any good practice related to the incident to be shared internally and externally
 - To identify any areas of concern and any lessons learned in relation to his care and treatment
 - To identify any learning from running an investigation for a case which is also under serious criminal investigation
- 5.3 The action plan is presented as a series of individual appendices to the report, and the findings, lessons learned and subsequent recommendations are listed under separate headings for each provider/agency, with a joint action plan that lists actions for the 'Joint Partnership', which refers to the substance misuse service, mental health service and housing provider), and for each individual agency.
- 5.4 The following contributory factors were identified:
- The service user had multiple conditions: schizophrenia, agoraphobia, anxiety, diabetes, a history of problematic alcohol and heroin use, personality and relationship difficulties.
 - He exhibited periods of lapse from heroin and alcohol use. The housing related support provider case notes state that illicit drug use and alcohol use was present in the weeks preceding the risk event.
 - The service user reported at times that he was not taking his mental health medication and methadone medication as specified.

- The service user's relationship with his partner had problems. The service user's partner was stabbed in the incident.
- The multi-agency dual diagnosis policy was not observed, a lead service was not in place to coordinate multi-agency care, and services did not work together to plan care and communicate effectively.
- Local mental health services report that their electronic record systems and 'FACE' tools do not easily facilitate the collation of relevant clinical information, including risk information.
- The drug treatment service worker had a high caseload at the time of the service user's case being open. Capacity and retention of staff team has been a historical problem for the service since the beginning of the services start in April 2011. Additional staff had been recruited to reduce caseloads and improve service user safety.
- Changes in service structures and teams across the county may have contributed to the lack of collaborative working.
- The collation of historical information regarding risk did not take place in a comprehensive way by the mental health service or drug treatment service.

5.5 A total of 17 recommendations were made across three agencies, with three of these focussed on the 'Joint Partnership' :

Joint Partnership

1. Complete a joint review of the processes and operation of the existing Dual Diagnosis guidance and protocol to understand and overcome obstacles that may be preventing this occurring.
2. Implement a multi-agency training and learning event on Dual Diagnosis including local protocols and procedures to ensure effective application of policies and guidelines and development of stronger working relationships and communication.
3. All communication that is relevant to supporting the service user effectively is to be shared with the multi-agency teams with the consent of the service user. This includes consultant psychiatrist review and drug and alcohol recovery service review letters being shared between services.

Mental health services

4. All Care Co-ordinators to check all current dual diagnosis cases for a multi-agency review within the last 6 months.
5. Review how complex cases are highlighted in team operational processes as being multi-agency in nature.

6. Electronic systems must be able to capture static and dynamic risk. Clinicians should be involved in the development of any review of new systems. Senior managers to initiate and oversee a review of risk assessment and management tools.
7. Clinicians to be reminded of liaising with partner agencies and the importance of timely record keeping.

Drug Treatment services

8. Service to collate a list of all dual diagnosis service users and identify which ones are currently working with mental health services in order to support the initiation of joint work.
9. Review the current case notes protocol and update guidance as required including completed examples of case notes. Implement in practitioner supervision and team governance meetings.
10. All practitioners to be instructed to be compliant with 6 weekly care plan intervals.
11. All practitioners to be instructed to be compliant with re-engagement protocol.
12. All practitioners to be instructed to complete drug screens at every medical review and make a case contact note following this. Governance Lead to evaluate how recording of this information takes place and implement any new guidance as required.
13. Implementation of enhanced risk assessment and risk management workshop.

Housing related support provider

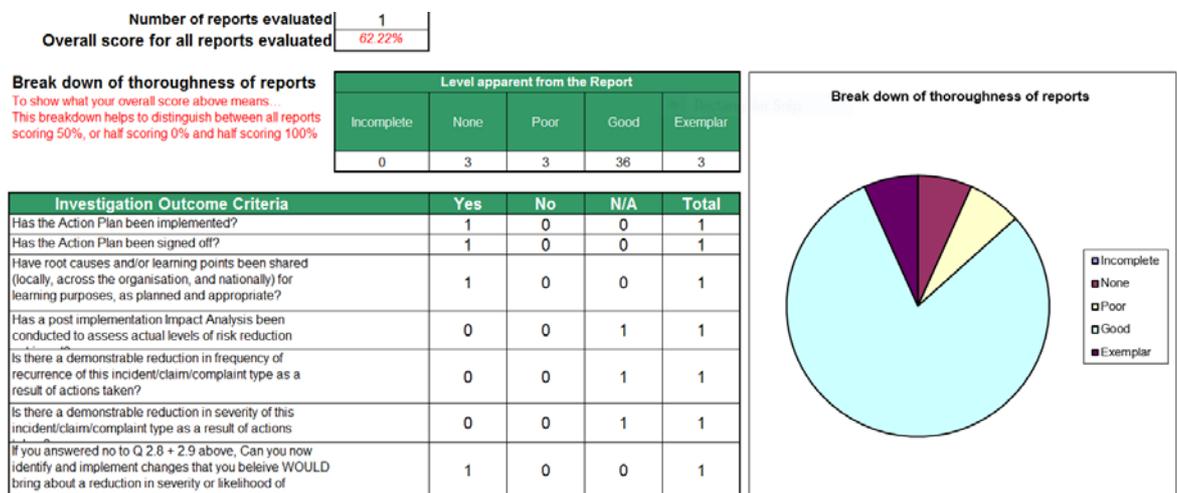
14. The housing related support provider should consider the development of a protocol to specify how joint work and communication might take place with service user agreement, with services that are providing treatment and care to shared clients.
15. The housing related support provider should identify cases where their service users are also receiving treatment and care from mental health services or the drug and alcohol recovery service and consider with the service user if joint working and communication might benefit the service user.
16. The housing related support provider should attend any planned partnership dual diagnosis training and learning event.
17. The housing related support provider, as part of the Ipswich Locality Homelessness Partnership, should prompt and support the co-ordination of a joint meeting or forum where the Locality partners,

mental health services and drug and alcohol recovery services could meet to build relationships, to understand the role of each individual service and consider the development and application of policies and procedures to promote joint working.

Comment and analysis

5.6 The internal investigation noted that it was not possible to determine a root cause, citing the ongoing police investigation, and lack of information about Mr K’s mental health after the homicide. This suggests that the internal investigation authors wished to clarify information on Mr K’s mental state after the homicide, and then consider whether this was a causal contributory factor in the homicide.

5.7 We have applied the NPSA credibility and thoroughness checklist¹⁶ to the internal report, and this showed a score of 62.22%.



5.8 The three ‘exemplars’ identified using this tool were:

- The incident description, (date/type/specialty/actual effects on patient/severity)
- The actual severity of the incident
- The details of the investigation team, including appropriate use of membership from other disciplines/agencies.

5.9 The three areas for improvement identified using this tool were:

- Evidence of appropriate involvement in and support of patients, families, carers during the investigation
- Appropriate distribution/circulation (relating to families) and

¹⁶ <http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847>

- Identification of a root cause.

In essence, the report should show a clear thread connecting: 1. The root cause(s) (in organisational processes); 2. How these directly resulted in the specific care and service delivery problems; 3. How these led to the documented actual or potential effect on the patient.

5.10 The internal investigation report states it was not possible to identify a root cause due to ongoing police investigations. It is not clear how this prevented the identification of a root cause. The National Patient Safety Agency guidance¹⁷ identifies the root cause as the:

- ‘earliest point at which action could have been taken to:
- strengthen the support system for appropriate care to be delivered,
- avert the cause of the incident or prevent its occurrence, and
- significantly reduce its impact or recurrence’.

5.11 It is not clear why the police investigation hindered this process, and we are mindful of the possibility of hindsight bias. While there is no obvious causal link between Mr K’s fatal assault on Russell and a known deterioration in his mental state, it is clear that the support system around Mr K would have been strengthened by the proper implementation of the Dual Diagnosis policy, identifying a lead agency, and ensuring all information about his care was shared in a timely way.

5.12 We note that the internal investigation report does not mention the lack of risk formulation, although it does highlight the lack of risk assessments, and this was picked up in the action plan.

5.13 The findings in the report are accurately reflected in the recommendations for all the provider agencies, however only implicit reference is made to primary care.

5.14 We agree with the five process and practice contributory factors identified by the internal investigation, which were as follows;

- The multi-agency Dual Diagnosis policy was not followed, and a lead service was not in place to coordinate care, and therefore services involved were not working together to plan care and communicate effectively;
- The drug treatment worker had a high caseload at the time. Capacity and retention of the staff team had been a historical problem since the

¹⁷ NPSA ‘Root Cause Analysis (RCA) toolkit’

beginning of the service contract in 2011, and was being addressed by recruitment;

- Mental health services reported that their electronic recording and risk assessment forms (FACE)¹⁸ did not easily facilitate the collation of clinical and risk information;
- Changes in service structures and teams across the county may have contributed to the lack of collaborative working;
- The collation of historical information regarding risk did not take place in a comprehensive way by the mental health service or the drug treatment service.

- 5.15 We were able to identify inadequacies in identifying key historical information, lack of robust formulation, and a lack of detail related to known risk factors.
- 5.16 Of particular concern is that detailed history of Mr K's violence with a bladed weapon is not recorded clearly and consistently (see recommendation 1).
- 5.17 One of the roles of a lead agency would be to oversee the process of risk assessment and care planning and establish communication pathways to maximise care delivery. The effect of this in the case of Mr K was that risk was not thoroughly assessed and the risk management plans were therefore incomplete. There was no risk formulation in place, although some risk factors were identified on his FACE risk assessment.
- 5.18 The electronic record system and FACE risk assessments did not result in robust risk management plans, leading to what the internal investigation refers to as 'insufficient information' in the care plan.
- 5.19 We found that the FACE risk assessment (June 2012) was incomplete, did not have a formulation which informed treatment, and seems somewhat confused at times in identifying historical and current risk factors.
- 5.20 A decision was made to alter the approach to his care when improvements in Mr K's compliance were noted. The decision to move from two professional contacts to one (the consultant psychiatrist) was undertaken without consultation with the remaining provider agencies either before or immediately after the decision had been made.
- 5.21 There are gaps in the CRI drug service records in clinical e-records from December 2012 to March 2013, and April to June 2013. It is noted in the internal report that on interview, the keyworker stated that there were more appointments than documented. The non-attendance by Mr K was not documented.

¹⁸ FACE assessment tools are nationally-accredited by the Department of Health and used throughout the UK & Ireland by NHS, social care and independent sector organisations. <http://www.face.eu.com/solutions/assessment-tools>

- 5.22 Whilst risk reviews were undertaken and were not remarkable, the drug service did not review Mr K's care plan at the recommended six week intervals. The case notes also suggest that Mr K's drug screening requirement at medical reviews was not always met. He was screened however at the last joint meeting on 25 May 2013 when it was reported that he had recently been using alcohol excessively.
- 5.23 Both the mental health and drug treatment services had met with the Mr K in April and May 2013 and both record that he showed no signs of significant changes in risks.
- 5.24 The housing related support worker did note however that there had been fluctuations in Mr K's 'experience of well-being' as well as short lapses of heroin use. It was also noted that he had been self-managing his methadone intake. An entry by his CCO on 12 September 2012 states that he had a lapse into heroin use in April. This was short lived and raised no increased concerns.
- 5.25 In the case note entry on 11 November 2012, it is noted that Mr K did not feel there was a role for his CCO as he was happy with most aspects of his life plan. This was the meeting before his discharge arrangements to one worker, were arranged. Of note is the CCO's entry where it states that Mr K was '*still fantasising about hurting people*', and both his partner and mother were aware of this. This disclosure did not result in any specific concern or intervention.
- 5.26 Only one multi-agency review took place on 5 December 2011, with CRI, and the consultant psychiatrist. There is no further evidence of multi-agency review for the 18 months prior to the offence.
- 5.27 The internal investigation report concludes that an identified lead agency in place and a multi-agency approach to case management and communication may have allowed a fuller view of Mr K's presentation.
- 5.28 A number of contributory factors related to Mr K were identified:
- Mr K had multiple conditions, including schizophrenia, anxiety, diabetes, a history of alcohol and heroin use, and personality and relationship difficulties.
 - Mr K was also known to have exhibited periods of lapse into heroin and alcohol use and there were incidences where he was known to have not taken his methadone prescription as planned.
 - It is suggested by the internal report that by two agencies prescribing methadone (CRI) and anti-psychotic medication (Trust), monitoring of his concordance may have been affected. Mr K reported at times that he was not taking his mental health medication and methadone medication as specified.
 - Mr K's relationship with his partner was at times problematic.

5.29 We concur with the above findings in the internal report and there is evidence that they have been considered in the formulation of his original care plan in 2008. Since this time, they have been considered in individual and multi-agency reviews, although his diagnosis was still said to be uncertain.

The risk profile (12 January 2012) and the CPA Health and Social assessment (21 June 2012) both make reference to the specific personal factors.

6 Analysis of progress since the internal investigation

- 6.1 The way in which drug and alcohol treatment in Suffolk is provided has changed markedly since 2013. Prior to April 2015, drug and alcohol treatment in Suffolk was provided by six different agencies. Specialist provision for adults, both clinical and psychosocial, alcohol users, young people and those linked to the criminal justice system were commissioned separately but as part of an overall treatment system across the county.
- 6.2 In order to integrate existing provision, Public Health Suffolk commissioned one overarching service to include all elements of treatment. This ensured the pathway for clients was easier to navigate without the need to access a number of services to address their addiction.
- 6.3 The 'joint partners' relevant to the action plan are now:
- The Trust (NSFT) (providers of mental health services)
 - Public Health Suffolk (commissioners of drug and alcohol treatment)
 - Turning Point (providers of drug and alcohol treatment)
 - IHAG (providers of housing support in Ipswich).
- 6.4 The action plan from the internal investigation addresses the issues identified by the internal investigation appropriately and applies the findings to joint partnership working in NHS (with the exception of primary care) and independent providers; that is the Trust, CRI and IHAG.
- 6.5 The joint partnership recommendations call for a joint review of the processes and operation of the existing Dual Diagnosis guidance and protocol. This is to include the implementation of a training and learning event to address the application of the guidance.
- 6.6 The final recommendation provides an instruction that all communication relevant to supporting the service user effectively is to be shared with the multi-agency teams.
- 6.7 With regard to Trust mental health services, four recommendations were made:
- Care Co-ordinators to check all current dual diagnosis cases for a multi-agency review within the last 6 months.
 - Review how complex cases are highlighted in team operational processes.
 - The electronic record system needs to be adapted to facilitate the inclusion of 'static and dynamic' factors of risk and that practitioners should be involved in this update. Senior managers to initiate and oversee a review of risk assessment and management tools.

- Clinicians to be reminded of liaising with partner agencies and the importance of timely record keeping.

6.8 The Drug Treatment service (CRI) recommendations include :

- A review of case notes protocol occurs with the issues to be addressed and that this is implemented in supervision and team governance meetings.
- There are three recommendations which provide instruction that practitioners are compliant with six weekly care plan reviews, be compliant with re-engagement protocol and complete and record drug screens which are taken at each medical review.
- An 'enhanced' risk assessment and risk management workshop takes place.

6.9 The recommendations for the housing related support provider include:

- to consider the development of a protocol to specify how joint work and communication might take place.
- the housing related support provider should identify which cases are also receiving input from Mental Health services to ascertain if joint working may benefit the service user.
- the housing related support provider should 'prompt' and support a joint meeting of the locality homelessness partnership, mental health services and drug treatment services in order to gain understanding, build relationships and consider the possibility of new policies and procedures.
- the housing related support provider should attend the joint learning and training event.

The internal action plan outcomes

6.10 The internal investigation report was commissioned by Public Health Suffolk, and although we have found that individual actions have been taken forward, there has been no coordination or oversight of the action plan, until this was raised as part of this independent investigation. A multi-agency meeting was held in August 2017 to review the implementation of the action plan.

6.11 As part of this review, it was highlighted that the families of Russell and Mr K have not had sight of the internal investigation report, and plans are in place to rectify this.

Recommendation 2:

Public Health Suffolk should ensure that if a multi-agency investigation is commissioned there is a mechanism to oversee the implementation of the action plan and the involvement of family and carers; serious incident investigation policies should be updated to include this requirement.

- 6.12 In this case there was a clear intention to involve families, and this was not possible because the police made a direct request that families should not be contacted. However, this was not followed up after the conclusion of the the criminal justice process.

Joint Partnership actions

- 6.13 A multi-agency shared learning event was held in September 2014, arranged by NSFT, Public Health, CRI and IHAG. The presentations, attendee list and feedback forms all demonstrate that this event was used to share lessons learned from the internal investigation, present the recommendations and work on joint actions.
- 6.14 This was followed by a multi-agency 'learning from experience' event in March 2015, with presentations from each service on action planning and joint working for the future.
- 6.15 NSFT shared the reconfiguration of services, the staff team, the Suffolk Integrated Delivery Team (IDT) model; explaining the process of referral, complexity of need and level of engagement, service user description, working practice and details of the provision of services.
- 6.16 The formal joint review of the processes and operation of the Dual Diagnosis guidance and protocol remains outstanding. However these recent actions have been undertaken:
- Recovery Forum (led by Public Health with good attendance from a range of organisations supporting substance misuse) in Ipswich on 14 June 2017 which focused on Dual Diagnosis with presentations from Turning Point and the Trust.
 - Public Health, Turning Point, the Trust, IHAG and ILHP (Ipswich Locality Homeless Partnership) met on the 12 September 2017 and agreed the following actions:
 - ILHP, IHAG, Trust and Turning Point and to review protocols & sign up;
 - Provider partners to meet quarterly to audit & review issues & learning; Use the Recovery Forums in West Suffolk & Waveney to look at dual diagnosis to share good practice from care coordination protocol and

- Agreed a role for housing in relation to dual diagnosis in Ipswich Forum.

Recommendation 3:

The joint partnership should complete a formal audit of the existing multi-agency Dual Diagnosis guidance and protocol and ensure it is fit for purpose and implemented across the agencies.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

Mental health services actions

- 6.17 The Trust have provided information related to their processes for ensuring families are involved and updated during serious incident investigations. A condolence letter is sent by the Chief Executive Officer, and there is evidence that this has been adjusted after feedback from families. The Trust monitors the application of the Duty of Candour and has provided detailed figures.
- 6.18 It is acknowledged by the Trust that there was no register developed of which clients were reviewed within the six month deadline from the internal investigation. However the new protocols and practice indicate that where relevant all service users are jointly reviewed on an ongoing basis. The Trust's new electronic clinical record system (Lorenzo) has an inbuilt 'patient review' functionality where practitioners can see when reviews occur, who attends and where it took place.
- 6.19 The structures in place to deliver and oversee mental health care in the community have been redesigned since this incident. There is now a local Integrated Delivery Team (IDT) in each area, to oversee the coordinated delivery of community mental health services in each designated locality. The Trust report that case management and supervision structures were used to check this at the time, but no formal summary was maintained.
- 6.20 On the issue of those complex patients who require a multi-agency response, the IDT has a formal morning meeting system, which provides the opportunity for complex patients to be discussed within the multidisciplinary team, which would include an overview of Dual Diagnosis clients. The outcome of these discussions would be recorded on Lorenzo and in the clinical team meeting minutes.

- 6.21 A further outcome is that it is confirmed that all clinical information, including GP letters, will be shared with Turning Point, where they have an active involvement in providing support.
- 6.22 The process for reviewing the service users' care package (the CPA review meeting), now includes invites to Turning Point staff to attend. They fully contribute to the review process and as agreed with the service user will be given a copy of the updated care and risk management plans, as well as the clinical team meeting minutes.
- 6.23 Turning Point have commenced the practice of attending protected time sessions with Integrated Delivery Team (IDT) community staff, usually the care coordinator, to discuss Dual Diagnosis clients, and improve engagement between the two services. It is reported by the Deputy Director of Operations Suffolk that feedback from managers suggests that this has led to the benefit of an increase in confidence within both teams in managing Dual Diagnosis service users, however this has not been objectively tested.
- 6.24 The Trust business intelligence system (Abacus) allows data technicians to produce reports of upcoming reviews and send these to clinicians as a reminder. A weekly report is sent to the locality managers listing service users who are overdue for review. It is noted that compliance is being achieved against a target of 95% of service users having had a review in the last 12 months.
- 6.25 The measures taken to ensure care plan compliance are jointly managed by the services and health informatics. These are:
- On a fortnightly basis information on the existence of completed care plans, core and risk assessments is distributed to locality and business support managers. This is then checked for accuracy and any errors are followed up with clinicians and the system updated.
 - This list is held on a central database page where the technicians then update clinicians if they are in breach of protocol (i.e. the care plan is out of date). In April 2017, this information was used to provide a care plan summary report for all Clinical Team Leaders (CTL) and IDT managers which provided scores that helped them understand how the team is performing against practice expectations in care planning, core assessment paperwork, core assessment and risk assessment.
- 6.26 The above processes are augmented by the Trust's Clinical Governance Team audit of care planning compliance undertaken on an annual basis.
- 6.27 There is a new 'Did Not Attend' (DNA) policy where each new referral has their risk graded on a RAG (Traffic Light: Red/High, Amber/Medium and Green/Low) system at referral and again when received by the IDT. The person is then contacted by telephone to commence the formulation of risk. If this call is unanswered a second call is attempted and if this is unsuccessful then a letter is sent to the person requesting that they get in touch. If there is still no response, and after appropriate evaluation of risk and other

assessment information a decision on discharge is made and then communicated by letter to the GP and the service user.

- 6.28 The policy stipulates that in instances where there is concern of high risk, for example when someone is pregnant, has communication / language issues or concern about accommodation, then extra efforts to contact are made based on clinical evaluation. This would include a clinical visit. For ongoing cases the principle of two calls and a letter still apply.
- 6.29 In relation to our enquiry on how concerns are escalated and addressed, the practice is that all service users are tracked visually on display boards in the MDT meeting room, using a 'traffic light' system. Those service users who are assessed as red or green are discussed at the four MDT meetings held by the Adult Pathway Team.
- 6.30 Records are updated by the lead professional and include the clinical decision. Based on the clinical judgement and knowledge of risk a decision will be made on whether to put the service user on 'FACT' (Flexible Assertive Community Treatment). This decision is recorded on Lorenzo and step up care as appropriate is commenced. The duty worker for the day is familiarised with the case to ensure appropriate support can be provided.
- 6.31 To evaluate care plans from a qualitative perspective the Clinical Team Leaders (CTL) review clinical records with the staff member in supervision. This is recorded on a template designed to help monitor compliance with guidance as well as quality, and is retained by the Clinical Team Leader.
- 6.32 All service users in the Trust are now described as CPA or non (N) CPA. CPA means they are complex and require a multi-disciplinary approach. NCPA means they are less complex and usually supported by one lead professional (mainly doctors). Complex needs are described as: *Severe mental disorder, risk of suicide, self-harm to self or others, self-neglect, vulnerable, learning disability, multi-agency involvement, currently or recently detained under MHA, referred to Crisis/home treatment team, significant reliance on carers/own caring responsibilities, difficulty or disadvantage as a result of physical health, impairment, inability to access services, ethnicity, sexuality or gender issues. Key groups in the CPA are parenting responsibilities, dual diagnosis, history of violence or self-harm or unsettled accommodation.*
- 6.33 It is evident from this policy change that Mr K would be regarded as requiring CPA in the current services. As part of supervision, the CTL will review clinical records depending on confidence and professional judgment of the care co-ordinator. The supervision record is retained by the CTL.
- 6.34 The core assessment, risk assessment and care planning templates have all been reviewed, and are now embedded in the electronic clinical record system. Systems have been introduced to identify which care plans are in need of review and if the care plan has not been updated for at least 12 months.

- Lorenzo has a Patient Review functionality, where a care-coordinator/lead professional can quickly see when the last review took place, who was in attendance and where it occurred;
- The Trust 'Abacus' reporting system allows data technicians/administration staff on behalf of local teams to run a report of upcoming CPA/NCPA reviews and send reminders to the clinicians of those that are due and overdue;
- A weekly report is sent to locality managers listing those patients that are outstanding for CPA and NCPA and how compliance is being achieved against the target of 95% of all patients having a review in the last 12 months;
- Local data technicians/administration staff ensure review information is updated correctly, taking advice from clinicians where needed;

6.35 Systems to check care plan compliance have been developed, allowing managers to access regular detailed information on care plan and risk assessment compliance:

- A fortnightly report is received from the informatics department showing the existence of a finalised care plan, core and risk assessment. This is distributed to locality managers and Business Support Managers.
- This is checked for accuracy and any data entry errors are followed up with clinicians and corrected.
- The list is held on a central database page, where data technicians use the information to update clinicians if they are showing as breach for the existence of a care plan.
- From April 2017 this report is also used to provide a weighted care plan summary report for CTL and IDT managers, showing how well the team and each individual professional is performing on the existence of the core assessment, risk assessment and care plan.

6.36 The Trust Clinical Governance team undertakes audits of care planning compliance annually in conjunction with teams.

6.37 The NSFT 'did not attend' policy has been adapted locally is as follows:

- For new referrals – at referral each patient is assigned a risk assessment under the traffic light system (LOW/MEDIUM OR HIGH) and assessed again once the referral is received in IDT.
- They are contacted by phone to help formulate that risk. Where there is concern of high risk, the service user is pregnant, has language issues or there is concern about housing, there will be extra efforts to contact them, and based on clinical evaluation a doctor or /clinician visit will be arranged.

- If there is no response – there is another attempt by telephone
 - If still no response a letter is sent to the patient asking them to get in touch
 - If still no response after evaluating risk and the core assessment a decision is made to discharge or not, with a letter to the GP and patient
 - For ongoing cases – depending on risk, the same principles apply; two calls and then a letter.
- 6.38 The NSFT Dual Diagnosis Policy was updated in December 2014 to incorporate the learning from the Mr K investigation, and is due for review in December 2017.
- 6.39 NSFT clinicians attend the Suffolk Dual Diagnosis forum which has been in place for many years. This meets four times a year, and is attended by the joint partnership agencies. Attendance by partners has been sporadic, in 2017 it was decided to alternate the venues of meetings so that two take place at their venue, therefore ensuring attendance. The meeting numbers have dwindled, due to capacity to attend and competing priorities. No minutes were available to review.
- 6.40 The Trust has invested in specialised risk assessment training, using an external company to provide risk assessment training, which was designed to educate staff in the use of best-practice tools to recognise, assess and manage risks including suicide, self-neglect, violence and sexual assault. Case studies from local incidents including Mr K were used to support learning. The Trust target compliance is 90%, and the Ipswich IDT had 78% attendance in June 2017. Action is being taken locally to address compliance issues. All staff training is reviewed in management supervision and staff will be given actions to address any non-compliance issues and Team Managers have been asked to target the staff that have not booked on training.
- 6.41 The Trust induction programme picks up the relevant training for staff and is set on the electronic recording system, according to job role. This is reviewed by managers in supervision and shows on their staff systems – up to three months before running out and then sends alerts to both the manager and staff member.

Recommendation 4:

NSFT should evidence its improvement programme for care planning and risk assessment quality and compliance.

Drug Treatment services actions

- 6.42 As indicated above, the provision of drug and alcohol treatment services in Ipswich has changed to one provider since 2013. This is now provided by Turning Point, commissioned by Public Health Suffolk.
- 6.43 Turning Point currently collect data in respect of dual diagnosis and ask if clients have dual diagnosis and any emotional wellbeing/ concerns. The data collected is based on self-reported information. There is not currently a system in place to determine 'self-reported' dual diagnosis from those who have received a full diagnosis and are therefore under the care of mental health services. Good communication links between housing services and Turning Point were acknowledged.
- 6.44 Turning Point follow the national standard of 12-week reviews, which is the same across most services. There is a scheduling structure in place and on the case management system a message alerts a key worker when a client needs a care review. An administrative 'dashboard' is kept of all review intervals, and staff and managers are notified.
- 6.45 If a client does not attend an appointment then Turning Point will phone the client to check the client's wellbeing and to reschedule. If they cannot be reached via phone then they will send a letter and will on occasion, also attach a letter to the client's prescriptions if they have one to collect. If there is still no engagement they will implement the reengagement policy which in August 2017 was under review.
- 6.46 Turning Point undertake urine drug screening at the non-medical and medical assessment, and this is supported by policy expectations. A urine drug screen is undertaken prior to every medical review. If clients are taken into Custody, then they would be tested in Custody. Turning Point train all staff to use and read oral and urine drug screens prior to being able to carrying out these screens independently.

Housing related support provider actions

- 6.47 The Ipswich Locality Homelessness Partnership (ILHP) agreed a 'Joint Working Protocol: Identifying the Lead Agency when working in Partnership' document in June 2016. This document provides guidance on identifying the lead agency shared responsibilities, and information sharing in particular for front line staff. It has been designed to ensure that
- There is clear action oriented and documented communication between providers.
 - There is an identified Lead Agency responsible for coordinating the actions relating to care and support for service users and information sharing across partners.
 - There are agreed escalation processes to raise concern about coordination and/or joint working.

- 6.48 This document was agreed in June 2016, and was accepted at the Ipswich Locality Homeless Partnership Steering Group on 14 September 2016, with input from all organisations concerned. It was noted at the action plan review meeting on 21 August 2017 that this document remains in draft and has yet to be agreed and signed off by the relevant partner agencies.

Recommendation 5:

The 'Joint Working Protocol: Identifying the Lead Agency when working in Partnership' should be agreed, signed off and implemented by all partner agencies, within six months. Implementation should then be monitored.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

7 Overall analysis and recommendations

Predictability and preventability

- 7.1 Predictability is “*the quality of being regarded as likely to happen, as behaviour or an event*”.¹⁹ An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.²⁰
- 7.2 With reference to Mr K there were no indicators that a violent act was more likely to occur at the time of the homicide. His risk of violence to others was historical and there was no recent evidence of any escalation in risk or the introduction of new factors which had the potential to increase risk. We do not consider that the homicide of Russell was predictable by any of the services involved.
- 7.3 Prevention²¹ means to “*stop or hinder something from happening, especially by advance planning or action*” and implies “*anticipatory counteraction*”; therefore for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.
- 7.4 Mr K’s care was not coordinated across agencies, allowing information to be lost. Although this resulted in a lack of the expected coordination of his care, we do not consider that the homicide was preventable. There were no indications that his ongoing thoughts of harming others had increased in intensity. Previous use of a knife to cause harm had been while in an environment with other drug users. There were no indications that he may be at increased risk of using a knife in his home.
- 7.5 There is evidence of more structured oversight of the quality of care and care planning by the Trust and Turning Point, and training has been provided to support the development of more accurate risk assessments.
- 7.6 As part of our terms of reference we are required to consider if a similar incident/circumstances occurred today would the policies and procedures of all the providers of services prevent a reoccurrence? The question of prevention does not apply in this case, because we do not consider that this homicide was preventable by services.
- 7.7 The information supplied by the Trust and other provider services suggests that of all these factors have been addressed via policy and practice guidance update, enhanced monitoring, and increased emphasis on joint clinical and

¹⁹ <http://dictionary.reference.com/browse/predictability>

²⁰ Munro E, Runggay J, Role of risk assessment in reducing homicides by people with mental illness. *The British Journal of Psychiatry* (2000)176: 116-120

²¹ <http://www.thefreedictionary.com/prevent>

other collaboration. The suggested changes are intended to lead to an improvement in care provided and would benefit from evidence that provides assurance that these structures are effective.

Recommendation 6:

Public Health Suffolk should undertake an assurance audit of the implementation of the action plan from this independent investigation.

Recommendations

Recommendation 1:

The Trust should utilise the joint information sharing agreement with Suffolk Constabulary to clarify patients' forensic history, within the bounds of the accepted criteria.

Recommendation 2:

Public Health Suffolk should ensure that if a multi-agency investigation is commissioned there is a mechanism to oversee the implementation of the action plan and the involvement of family and carers; serious incident investigation policies should be updated to include this requirement.

Recommendation 3:

The joint partnership should complete a formal audit of the existing multi-agency Dual Diagnosis guidance and protocol and ensure it is fit for purpose and implemented across the agencies.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

Recommendation 4:

NSFT should evidence its improvement programme for care planning and risk assessment quality and compliance.

Recommendation 5:

The 'Joint Working Protocol: Identifying the Lead Agency when working in Partnership' should be agreed, signed off and implemented by all partner agencies, within six months. Implementation should then be monitored.

The joint partnership is comprised of :

- The Trust (NSFT) (providers of mental health services)
- Public Health Suffolk (commissioners of drug and alcohol treatment)
- Turning Point (providers of drug and alcohol treatment)
- IHAG (providers of housing support in Ipswich).

Recommendation 6:

Public Health Suffolk should undertake an assurance audit of the implementation of the action plan from this independent investigation.

Appendix A – Terms of reference

An external verification and quality assurance review is intended to be a verification of the multi-agency investigation report with limited further investigation to enable the review team to fulfil the terms of reference. This may be undertaken via a desktop review and is unlikely to involve detailed interviews with staff.

This investigation should focus on the areas highlighted by the multi-agency report, quality assure the investigation; and concentrate on the subsequent actions taken by the whole health economy and partner organisations.

- Review the existing investigation recommendations and action plans
- Review progress that has been made in implementing the recommendations and the learning from their multi-agency investigation
- Focus the investigation on the present day services and current processes.
- Review the appropriateness of the treatment of the service user, in particular the frequency of visits by mental health services and the substance misuse service
- Examine the effectiveness of the service user care plan including the involvement of the service user and the family and whether carers assessments were considered and undertaken
- Review the information sharing between all health organisations and housing related support
- Review the lack of lead agency and the implication on the service user treatment and whether a similar situation could occur today.
- Review the awareness and impact of the Trust Dual Diagnosis Policy both within the organisations and with relevant partner organisations
- Consider if a similar incident/circumstances occurred today would the policies and procedures of all the providers of services prevent a reoccurrence
- Involve the families of those affected as fully as is considered appropriate, in liaison with NHS England, Police and other identified support organisations.
- Consider if this incident was either predictable or preventable
- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation.

Appendix B – Documents reviewed

NSFT documents

- Clinical Records from NSFT including care and crisis management plan
- Paper copies of electronic case notes – ePEX
- FACE Risk assessment, Health and Social care assessments (Core Assessment)
- Drug Treatment Service clinical records
- The internal investigation report
- The internal investigation action plan
- NSFT Dual Diagnosis Policy December 2014
- NSFT CPA and Non CPA policy April 2017
- NSFT Clinical Risk Assessment and Management Policy July 2016
- NSFT Management of Health Records policy January 2106

Other documents

- The Ipswich Locality Homelessness partnership Joint working policy
- Primary Care correspondence
- Turning Point Drug screening and Testing policy (urine testing policy), for review April 2019
- Turning Point Faltering Engagement and Prescribing Guidance
- Suffolk Constabulary Information Sharing agreement with NSFT, Suffolk County Council (AMHP service), West Suffolk Hospital NHS Trust, The Ipswich Hospital NHS Trust and East of England Ambulance Service