Niche PATIENT SAFETY

NHS England

An independent investigation into the care and treatment of a mental health service user (JK) in Southampton

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Contents

1 Executive summary 5
2 Approach to the investigation 8
Structure of this report 10
3 Summary of the incident 11
4 Short chronology of JK's life 12
5 Critical events and factors in the care and treatment of JK 13
A. History of assaults and prosecutions 13
B. Admission to the department of psychiatry and forensic opinion 14
C. Discharge from enhanced CPA, from the caseload of his care co-ordinator and record keeping 15
D. Diagnosis, medication and appointments in outpatients 18
Diagnosis 18
Medication 18
Outpatient appointments 19
E. Evidence of relapse in early 2014 21
F. Risk assessment and the transmission of risk information 22
G. Family support and liaison 26
6 The Trust's internal investigation 30
The recommendations arising from the internal investigation 31
7 The Trust's action plan 33
8 The independent investigation's commentary on the internal investigation 37
The independent investigation's findings 37
If JK had been a patient in the service in 2016 37
9 Further contributory factors (additional to those in the internal investigation report) 38
10 Predictability and preventability 40
11 Recommendations 42

Appendix A 43
Purpose and terms of reference of the investigation.. 43
Appendix B 45
Medication 45
Appendix C 48
Number of psychiatrists involved between 2011 and 2014 48
Appendix D 49
Aims and objectives of the Trust's internal investigation.. 49
Appendix E. 51
Southern Health's action plan 51
Appendix F 58
Outline of Southampton Improvement Plan 58
Appendix G.. 62
Southern Health NHS Foundation Trust 62

1 Executive summary

1.1 This independent investigation was commissioned by NHS England to review the care and treatment provided to JK by the mental health service of Southern Health up to the time of the homicide in June 2014. The terms of reference are at appendix A.

1.2 On 24 June 2014 JK stabbed an older man, Mr W, outside the guest house where JK rented a room. Mr W was a friend of JK's landlady and had been known to JK for many years. Mr W died in hospital shortly after the assault.

1.3 JK was born in 1979 in Southampton. His early childhood was relatively uneventful and he described it as happy. He attended mainstream schools, but got into trouble regularly. He initially lived with his mother, who was separated and later divorced from his father, and lived with his father from the age of 14. After the age of 16 he reported that he lived on his own. He was an occasional cannabis smoker. Following school, JK undertook a degree in management sciences. During this time he had his first feelings of suspicion about others. Following his degree he worked in a number of short-term casual and manual jobs and later was unemployed. He lived at many different addresses in Southampton, including the guest house where the homicide took place.

1.4 There were a number of instances of violence and aggression and he had a ten month admission to an acute inpatient unit on a hospital order in 2006/7. During his admission he had a forensic assessment and was diagnosed with paranoid schizophrenia.

1.5 After discharge from hospital he was initially on the care programme approach (CPA) but was discharged from the caseload of his care co-ordinator in 2011. After this he continued to be seen in outpatients by a number of locums and junior doctors who amended his medication and communicated with his GP. Although there were a number of relapses over the following years he often reported that he felt fairly stable. However he lived a fairly isolated life, apart from his contact with his immediate family, and was unemployed much of the time.

1.6 JK was seen in the outpatient department by Dr J the day before the homicide. He had been experiencing a relapse but appeared to be becoming more settled at that appointment.

1.7 Following the stabbing he left the scene and went to his mother's home. His parents then accompanied him to the mental health inpatient unit where he hoped to be sectioned. He was arrested at the mental health centre. JK was later found guilty of murder.

1.8 Southern Health set up an internal investigation, chaired by an independent investigator. The investigation panel reported to the Trust in spring 2015. Their findings and recommendations are included in this report at section 6.

1.9 This independent investigation has had access to the documents and transcripts used by the internal investigation. We have also scrutinised a number of statements, policies and reports and have interviewed senior members of Trust staff.

1.10 This report highlights and analyses a number of themes including:

- JK's history of assaults
- risk assessment and the transmission of risk information
- discharge from CPA and from the caseload of his care co-ordinator
- liaison with JK's family
- record keeping
- signs of relapse.

1.11 Our independent investigation broadly agrees with the findings and recommendations of the internal investigation. We have in addition identified some further contributory factors:

- No continuity in those providing JK's care from the end of 2010, so that there was a lack of knowledge of JK as a person and of his mental ill-health.

- A lack of recognition of JK's specific relapse signs or discussion with him or his family on these, and therefore no systematic use of his relapse signs/indicators to review his mental health.

- Limited ongoing dialogue with family members about JK's mental health. Some discussion with JK's mother in the weeks before the homicide, but no triangulation through a meeting with her or with her and JK.

1.12 We have also commented on the lack of scrutiny of the internal report by Southern Health's Board or Quality and Safety Committee.

1.13 We have made the following six recommendations:

Recommendation 1:
The Trust's care pathways should give due prominence to the importance of having one or two key members of staff who can provide continuity of care for a long-term service user.

Recommendation 2:
The Trust should adopt and more closely follow the NICE schizophrenia quality standards[1] and the Royal College of Psychiatrists' good practice guide[2] particularly in relation to risk assessment and risk management, family education and support, relapse indicators, social circumstances, engagement and psychological interventions.

Recommendation 3:
The Trust should develop a policy and practice guidance on family engagement during an episode of care (including possible family meetings).

Recommendation 4:
The Trust should develop guidance on family support and access to information after a serious incident, to include guidance on implementation of this and the Duty of Candour policy.

Recommendation 5:
The Trust should ensure that the lead for liaison with family members and carers after such a serious incident should be at executive director or equivalent level, in accordance with the NPSA good practice guidance. This director would not necessarily carry out all contacts but would make the initial contact and would guide the continuing support and information sharing.

Recommendation 6:
The Trust should ensure that future reports and recommendations following a particularly serious incident should be formally reviewed and discussed by the Trust's executive and non-executive directors.

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[1] *NICE. Psychosis and schizophrenia in adults. February 2015. https://www.nice.org.uk/guidance/qs80*

[2] *Royal College of Psychiatrists. August 2016. Assessment and management of risk to others. Good practice guide. http://www.rcpsych.ac.uk/pdf/CR201GPGx.pdf.*

2 Approach to the investigation

2.1 This independent investigation has been commissioned by NHS England under Department of Health guidance (94) 27[4], on the discharge of mentally disordered people and their continuing care in the community, and further updated paragraphs 33-36 issued in June 2005 and the NHS England Serious Incident Framework[5] (March 2015). The terms of reference for this investigation are given in full in Appendix A.

2.2 The investigation was into the care and treatment provided by the Southampton mental health service in Southern Health NHS Foundation Trust (the Trust) to JK up to the time of the homicide of Mr W in June 2014.

2.3 There are two main purposes of an independent investigation. First, it is to identify areas where improvements to services might be required which could help prevent similar incidents in the future. Second, it is to discover whether there were any aspects of the care which could have altered or prevented the incident. The team have followed the relevant sections of the National Patient Safety Agency guidance[6].

2.4 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning. This particular investigation was preceded by a thorough and detailed Trust internal investigation which has informed our work.

2.5 The investigation was carried out by Sue Simmons, investigator for Niche, with expert advice provided by Dr Mark Potter and peer review by Christopher Gill. The report was further peer reviewed by Carol Rooney, Senior Investigation Manager.

2.6 The investigation team will be referred to in the first person plural in the report.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance. Published documents referred to are detailed in footnotes.

2.8 We used information from JK's clinical records and evidence gathered from the internal investigation report. We were not able to access JK's primary care records but saw many copies of letters written from the mental health service to his GP. As part of our investigation we interviewed:

- the chair / main author and a second member of the panel of the internal investigation;
- senior members of Trust staff about governance issues;
- Trust managers and leaders in the Southampton area about the Trust's action plan.

[4] *Department of Health (1994) HSG (94)27: Guidance on the Discharge of Mentally Disordered People and their Continuing Care, amended by Department of Health (2005) - Independent Investigation of Adverse Events in Mental Health Services*
[5] *NHS England Serious Incident Framework March 2015.*
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
[6] *National Patient Safety Agency (2008) Independent investigations of serious patient safely incidents in mental health services.*

2.9 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature.

2.10 We had access to the Trust's papers produced at the time of the internal investigation. We also reviewed a number of Trust clinical policies which were current in 2006, 2010, 2014 or 2016.

2.11 We wrote to JK at the start of the investigation, explained the purpose of the investigation and asked to meet him. We then met him at HMP Winchester. JK gave NHS England written consent for us to access his medical and other records.

2.12 We met JK's mother and father and explained the purpose and process of our investigation. They also shared their views on the care and treatment received by their son. We also had some discussion with his sister.

2.13 We spoke to one of the victim's sons, by telephone, and communicated by email. The family did not wish to contribute further to the investigation into mental health services, but shared information about the contact they had had from the Trust.

2.14 The documents from these sources were then rigorously analysed to develop themes and findings, and in particular to identify factors which may have contributed to the incident. Wherever possible information was triangulated, that is checked against other sources for reliability. As far as possible we have endeavoured to eliminate or minimise hindsight or outcome bias[7] in this process. We have endeavoured to work with the information which was available to the Trust team at the time. However, where hindsight has informed some of our judgements we have identified this.

2.15 The investigation team and NHS England had meetings with both families and JK to feed back the findings of this report.

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[7] *Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgement and assumptions around the staff closest to the incident.*
Outcome bias is when the outcome of the incident influences the way it is analysed, for example when an incident leads to a death it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

Structure of this report

2.16 Sections 3, 4, and 5 include a summary of the incident, a short chronology, and a summary of and comments on a number of key themes relating to JK's care and treatment.

Sections, 6, 7, 8 and 9 review the Trust's internal investigation and report on progress made in addressing the matters raised.

Section 10, 11, and 12 include further recommendations and comments on predictability and preventability.

2.17 The initials JK bear no relation to the actual name of the perpetrator.

2.18 The doctors involved in JK's care have all been given initials starting with A,B,C,D and so on.

2.19 We would like to express our condolences to the family and friends of Mr W and to thank the family for their help with our investigation.

2.20 We would like to thank interviewees and members of staff of the Trust for their help and co-operation.

3 Summary of the incident

3.1 This summary has been informed by the psychiatric court reports, clinical records and a discussion with JK.

3.2 At the time of the incident, 24 June 2014, JK was living in the guest house that he had lived in for approximately three years. He was friendly with his landlady and had known Mr W, the victim, for around ten years. JK reported that he and Mr W had had fights in the past. JK was in his room when his landlady telephoned him to ask for some help with bringing bags of shopping into the house. When he opened the door Mr W was also there. JK alleged that Mr W was drunk, was abusive to him and tried to punch him. However we have not been able to corroborate this allegation.

3.3 JK helped his landlady in with her bags and shut the door, leaving Mr W on the outside. JK reported that his landlady did not wish to see Mr W and asked JK to give him a meal and his bicycle. At this point JK said that he thought he could kill Mr W, and that he thought that if he killed someone it would bring about the end of his suffering and provide him with answers.

3.4 JK took a knife and stabbed Mr W three times in the neck. Mr W died later in hospital.

3.5 JK then took a route away from the main road to his mother's flat and on the way telephoned his sister to say that he 'had done a bad thing' and may want to come to Bristol for a few days. He threw the knife into bushes in a garden. He told staff later that he called the emergency services but there was no record of him telephoning.

3.6 When he arrived at his mother's she contacted his father who came round. His parents tried to persuade him to go to the police, but instead they all then went to the out-of-hours team in the Southampton mental health service, where he was seen by two members of staff.

3.7 He told them he had been in a fight with Mr W, had experienced a 'red mist' and had stabbed him. He wanted to be detained under the Mental Health Act and asked them not to contact the police, saying he would go to the police with his solicitor the next day. The police arrived while he was there and he was arrested on suspicion of murder.

3.8 JK was taken to Winchester prison on remand and charged with murder. In April 2015 he was transferred to Ravenswood House, a medium secure unit, under section 48 of the Mental Health Act 1983 (MHA)[8] for mental health assessment.

3.9 At his trial in June 2015 JK was convicted of murder and subsequently sentenced to life imprisonment with a twenty year tariff.

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[8] *Section 48 of the Mental Health Act (1983) empowers the Secretary of State to direct the transfer of a remand prisoner to hospital for treatment.*

4 Short chronology of JK's life

4.1 JK was born in 1979 in Southampton. His early childhood was relatively uneventful and he described it as happy. His parents separated when he was four years old and he initially lived with his mother but continued to have regular contact with his father. He attended mainstream schools. He moved to live with his father when he was about 14 years old, but reported that he lived on his own from the age of 16. His mother lived in Spain for 12 years and moved back to Southampton in 2012.

4.2 He reported that he smoked cannabis almost daily from the age of 14 or 15 up to around 18 years old. He also told staff that he took amphetamines occasionally but had not done for many years by the time he had contact with mental health services.

4.3 JK completed secondary education although he was repeatedly in trouble at school. He then undertook and completed a degree in management sciences at Southampton University. He worked in a number of short-term casual and manual jobs and later was unemployed, living on job seekers allowance. For a short period he lived in Bristol, but then returned to Southampton towards the end of 2005. He lived at many different addresses in the city. In some he had no facilities for washing his clothes or cooking. In 2009 his mother described his one-room flat as 'squalid with a leaking roof, blocked shower and wash basin and rotting food in the fridge'. At a number of different times, he lived at the guest house where the homicide took place. In June 2014 he had lived there for a continuous period of three years.

4.4 JK reported having few friends. However it appears he was a close friend of his landlady and through her saw her partner (Mr W, the victim) frequently.

4.5 He first had feelings of suspicion about others when he was at university. He was first referred to mental health services in Southampton in 2004 and was then under the care of Dr A, a consultant psychiatrist in the Southampton mental health service, until 2009, apart from a few months when he was in Bristol. There were a number of episodes of aggressive or violent activity and he was charged and found guilty of assault, actual bodily harm and assault by beating in 2005. He was remanded into prison and from there was transferred to the inpatient unit at the Department of Psychiatry in Southampton in 2006 for assessment and treatment, under the care of Dr A. He remained in hospital for ten months.

4.6 After his discharge, he was initially on the care programme approach (CPA) but was discharged from the caseload of his care co-ordinator in 2011. After this he continued to be seen in outpatients by a number of junior doctors who amended his medication and communicated with his GP.

4.7 In the months before the homicide he saw his mother several times a week as she cooked his meals and did his washing.

5 Critical events and factors in the care and treatment of JK

5.1 This section covers a number of themes in JK's care and treatment and includes some commentary on these themes.

A. History of assaults and prosecutions

5.2 JK's first contact with the police was at the age of 16 when he was convicted of affray resulting from a fight and he received a fine and community service order. In October 2004 Dr A, the consultant psychiatrist in Southampton who already knew JK, was contacted by the police. Apparently JK had been seen by a member of the public hiding in bushes in the town and then running away. Dr A telephoned JK who told him he was in Bristol and intended to stay there. There appears not to have been any further police action.

5.3 A year later in November 2005 JK was back in Southampton and facing a possible custodial sentence as a result of a prosecution for assault. Dr A saw him to write a report for the court and discovered that JK had been found guilty of three assaults and carrying a knife (which he said he carried for his own protection). JK told Dr A that the worst assault was when the person he was having a fight with sustained a fracture of the skull around the eyeball. Dr A also liaised with the Trust's mental disordered offenders service (MENDOS) and met JK's father for further information. In his report for the court Dr A said that he thought JK suffered from paranoid psychosis or delusional disorder and recommended a hospital order under section 37 of the MHA[9]. A bed in the department of psychiatry would be available. JK was admitted from Winchester prison on 5 June 2006 to Mitchell ward in the department of psychiatry in Southampton.

5.4 When in the hospital there were several attacks on other patients and one episode of a serious assault (including punching and wrestling to the ground) on an occupational therapist (OT) who had taken him out on escorted leave. The OT had a black eye and other facial injuries. It was thought that JK had misinterpreted the OT's behaviour and thought he was 'taking the mickey'.

5.5 In January 2007 JK attended court in relation to the assault on the OT. The case was adjourned for medical reports.

5.6 There were no further prosecutions until the time of the homicide. However JK did admit that there had been occasional episodes of aggression which were not reported. One of these occurred when he accused a friend of not telling him about the poisoning of his food and his surveillance. JK also reported that there had been, on occasion, arguments with Mr W, including an episode when JK said that Mr W attempted to run him over with his car and another episode when Mr W went to police accusing JK of assaulting him. It seems that neither of these allegations was taken further.

[9] *Section 37 of the MHA diverts an offender from a custodial sentence to a hospital for treatment.*

B. Admission to the department of psychiatry and forensic opinion

5.7 JK was admitted to Mitchell ward in the department of psychiatry on a section 37 of the MHA on 5 June 2006 from Winchester prison. Prior to his admission he had not been eating and believed his food was poisoned and that he was under surveillance. A nursing care plan was developed at the beginning of his admission and reviewed regularly thereafter. Dr A reported that for the first four weeks or so he was fairly settled.

5.8 After approximately one month JK became more disturbed and assaulted three other patients and a member of staff, and appeared to become increasingly paranoid. Staff had some suspicions that he was not taking his medication. On 23 July he told a member of staff that he had in the past followed two girls, something he would not normally have done. On 24 July 2006 he was transferred for around six weeks to Mayflower, the psychiatric intensive care unit. His section 37 was renewed in November 2006 and he was regraded to informal status in March 2007.

5.9 After the first few weeks during which JK presented a significant risk to others he appeared to settle on the ward, and accepted his medication. At that time it was reported by staff that he often appeared guarded when discussing his past history. He often isolated himself in his room and had limited interaction with staff and fellow patients. He had section 17 leave of absence and it was reported that he used this appropriately. At Christmas he had two nights of overnight leave to his father's house.

5.10 During JK's admission on Mitchell ward Dr A referred him for a forensic assessment, with a particular request for an opinion on diagnosis, risk assessment and management. He was assessed by Dr B, a specialist registrar in forensic psychiatry, towards the end of November 2006. This assessment was informed by a number of reports, scrutiny of his records, discussions with the senior nurse on duty and an interview with JK himself.

5.11 Dr B concluded that there was sufficient evidence to diagnose paranoid schizophrenia. In his opinion JK was 'immensely unwell', was guarded and quite flat in his presentation and the risk he presented to others was 'related directly to his mental illness'. In Dr B's opinion the risks posed by JK were as a result of his mental illness and were not personality driven. He believed that JK continued to pose a significant threat to others while he suffered with paranoid delusions and that the threat could be of physical assault or sexual assault, which could be impulsive and without warning.

5.12 Dr B recommended a trial of olanzapine[10] for six to eight weeks, and if this was not helpful to consider clozapine[11]. Finally he recommended that JK should be given some leave with appropriate supervision.

5.13 JK was discharged from the ward in April 2007 on the enhanced care programme approach (CPA). His care co-ordinator was to see him each

[10] Olanzapine is an antipsychotic oral medication that is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder

[11] Clozapine is an antipsychotic medication which is mainly used for patients whose symptoms have not improved with other anti-psychotic medications. It has significant and potentially serious side effects including the risk of low white blood cells and requires regular blood test monitoring.

week for six weeks, and he was to have fortnightly out-patient appointments with Dr A.

Comment

5.14 This was JK's first and only admission. It was a long admission and it appears that he took some time to respond to the prescribed treatment. It was noted that he was often guarded and tended to isolate himself. He did not talk freely about his thoughts and it was judged that his propensity for aggression remained, although it was managed by treatment.

5.15 It appears to us that his discharge plan was designed around these factors but was then diluted over the following years. Further the findings and opinion of the forensic assessment were not carried through to later risk assessments and risk management plans.

C. Discharge from enhanced CPA, from the caseload of his care co-ordinator and record keeping

5.16 During his admission to inpatient care JK was referred to the community mental health team for the allocation of a care co-ordinator. A social worker member of the team was allocated and initially followed up JK on a weekly basis after his discharge in April 2007. A second care co-ordinator became involved and at least twice saw JK with Dr A in outpatients. On a number of occasions Dr A and the care co-ordinator visited JK at his home The second care co-ordinator left the community mental health team in June 2008 and was not immediately replaced. JK was to be 'open to duty'[12].

5.17 In February 2009 in response to a period of JK's deteriorating mental health and an increase in his anxiety about his physical health, Dr A asked the home treatment team to meet JK and assess him for possible home treatment team involvement. However the senior practitioner and JK together agreed that there was no need for any involvement from the team.

5.18 In March 2009 Dr A wrote to the manager of the community mental health team pointing out that it was now a matter of urgency that a care co-ordinator should be appointed for JK. A third care co-ordinator was identified shortly afterwards. This care co-ordinator also appeared to have seen JK with Dr A on several occasions. There was a standard CPA care plan developed in December 2009 which set out a plan involving his consultant, care co-ordinator and a support, time and recovery (STR) worker.

5.19 JK told us that his first few years of contact with the mental health service went fairly well, and it was in 2010/11 that things started not to go so well.

5.20 In August 2010 the Trust moved to holding clinical records on the RiO system. The first record in RiO for JK appeared to be 5 August 2010. Some key

[12] *We understand this to mean that JK could contact the duty team if he felt unwell, but would not otherwise be seen by a member of the community mental health team, apart from appointments for his depot medication.*

reports for some patients were uploaded to the new system, but it appeared that this was not the case for JK. For around 12 months clinical staff in outpatients had access to the old paper records while using the RiO system for new records. However this did not continue beyond the initial period. It was therefore the case that some key records, including risk assessments, were not accessible to the team caring for JK. This happened at around the same time as there were changes to his care co-ordination arrangements.

5.21 In November 2010 it was planned to transfer JK's medical care from Dr A to Dr L as there was some reorganisation of consultant responsibilities. He would continue attending outpatient appointments and would receive his depot medication at the community mental health centre. JK's care co-ordinator continued to be involved initially through home visits and telephone calls. It was agreed at the end of March 2011 that JK would be discharged from enhanced CPA once he had 'settled with Dr L'. JK then saw a different locum consultant (Dr M) on his next outpatient appointment in April 2011. Nevertheless his care co-ordinator recorded that JK was discharged from his caseload on 19 April 2011 and wrote a closure summary at the end of June 2011 saying that JK appeared to be settled and no longer needed the support of a care co-ordinator. The plan was for him to continue to attend the outpatient clinic and to receive his depot medication from the community mental health team and his oral medication from his GP. This plan was confirmed in a letter to JK on 15 July 2011 which mentioned that JK could contact the duty service in the community mental health centre, between 9am and 5pm, if he needed help in the future. A letter was also sent to JK's GP.

5.22 From the date of his discharge from the caseload of his social worker care co-ordinator (and therefore from enhanced CPA) JK's care co-ordinator was recorded as being the psychiatrist he was assigned to in outpatients. We could find no reference to medical staff acting as care co-ordinators in Trust policies. The Trust's Care Planning Policy[13] referred to an allocated worker for all patients on CPA, and said that, if the service user had complex needs, this should be an identified care co-ordinator.

5.23 In the CPA records there was no reference to his eligibility for aftercare under section 117 of the Mental Health Act[14]. In fact a 'No' had been recorded in response to the question as to whether section 117 should be continued. His third care co-ordinator told the internal investigation that he was aware that JK had been eligible for section 117, but said that if he required more intensive intervention or a 'package of care' that could be arranged at the time of need.

Comment

5.24 In 2010 there were changes to record keeping, from paper to electronic, and at around the same time changes to the consultant and care co-ordinator who were caring for JK. The electronic records appear to have been incomplete as some important information was not brought forward to RiO. In addition as a result of the speed with which consultant roles were re-organised and the lack of a substantive consultant, there was no handover from Dr A to the new

[13] *Southern Health (January 2010). Care Planning Policy - Incorporating the Care Programme Approach (CPA) Version1*
[14] *Dept of Health 2015. Mental Health Act 1973: Code of Practice. Chapter 33.*

locum consultant. These two factors resulted in a loss of professional / organisational memory alongside the loss of written information.

5.25 We understand that in 2014 it would have been possible for JK to be referred to the shared care service (which started in January 2014) from outpatients. This service is for people who need extra support but not at the level of the hospital at home scheme. The team is able to respond in times of crisis by giving support, including in the evenings and at weekends. However JK was not referred to this service.

5.26 During the last four years of his contact with the mental health service it would have been particularly important for there to have been some consistency and continuity in his care. When he was seeing a different psychiatrist at almost every visit having a consistent care co-ordinator would have been particularly helpful.

5.27 It appears unlikely that the doctors who saw JK between 2011 and 2014 thought of themselves as having the role of his care co-ordinator. However Dr J who saw him for around six months before the homicide appeared to become involved in a more holistic way. He regularly spoke to JK's mother, took a real interest in JK's employment plans and referred him to relevant agencies which could support him in his endeavours to find work.

5.28 The third care co-ordinator acknowledged that JK had been eligible for section 117 after care after his admission in 2006/7 and that this had not been followed through, but said that if at any point he needed a 'package of care' that would be arranged.
Chapter 27 of the 2008 Code of Practice[15] (which would have been in operation in 2014) stated that "the duty to provide after-care services continues as long as the patient is in need of such services" and should not cease because of some arbitrary timescale or because the patient does not wish to receive a particular service.

5.29 There was no indication, in our view, that JK lacked access to any service that he needed because his eligibility for section 117 aftercare was overlooked. He had a care co-ordinator for three years after his admission during which time he was mentally stable, and was offered, at different times, help with accommodation, with looking for employment, day hospital care and contact with the home treatment team and generally turned them down.

5.30 However acknowledgement that he had section 117 entitlement to health and social care, and his registration for this entitlement, could have identified to those providing his care that he had had an admission under section 3 or 37 of the MHA in the past and that he was potentially vulnerable to significant further breakdown of his mental health.

[15] *Department of Health. MHA Code of Practice 2008.*

D. Diagnosis, medication and appointments in outpatients

Diagnosis

5.31 There was initially some variability in JK's diagnosis although there was agreement that he suffered from a paranoid and delusional disorder. Initially in early 2006 Dr A diagnosed paranoid personality disorder or paranoid psychosis. The forensic psychiatrist who assessed JK in Mitchell ward in November 2006 thought he had paranoid schizophrenia and the discharge summary from Mitchell ward recorded it as paranoid schizophrenia currently in remission. This diagnosis remained on his records up to the time of the homicide. One of the consultant psychiatrists who assessed him after the homicide for the court thought that his ill-health could be classified as persistent delusional disorder.

5.32 There were frequent references in the records to JK being quite guarded in what he told staff about his thoughts and feelings. JK told us that he found it very difficult to talk to someone he did not know and preferred to say that everything was fine. He added that he was concerned that he would have been detained under the MHA if he had told medical staff how he was feeling. This made it very difficult for staff attempting to assess his mental state. Interestingly Dr K and Dr J who were involved with JK in the months prior to the homicide did not agree with the description of JK as guarded. In their view he was open and collaborative.

Medication

5.33 There did not appear to be any difference of opinion on the appropriateness of treatment with anti-psychotic medication. There were however some changes. JK reported experiencing relapses and recovery quite quickly at times of changes to his medication. The details of his prescriptions from 2004 to 2014 are set out in appendix B.

5.34 It is the opinion of the panel that overall the medication prescribed seemed reasonable and generally within British National Formulary[16] limits. Side-effects appear to have been monitored. Clozapine (used for treatment resistance) was suggested in the forensic opinion in 2007, but there is no record of this being discussed with JK or considered by the medical staff.

5.35 JK had been on a low dose of depot medication (fluphenazine[17]) and, in addition, oral anti-antipsychotics. Dr A had earlier attempted to increase his fluphenazine from 25mg to 37.5mg but found that JK experienced an increase in side effects, and therefore reduced it again. This was unfortunate as depot medication may have aided compliance. However in Dr A's judgement the combination of depot and oral medication worked well.

5.36 There were some rapid changes to his medication in 2014. JK had had a negative reaction to aripiprazole[18] in 2008. However this was not known to

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[16] The British National Formulary (BNF) is a reference book containing information on prescribing and pharmacology of many medications, including indications, contraindications, side effects, doses, and legal classification.

[17] Fluphenazine is a long-acting anti-psychotic medication, given by intramuscular injection to treat the symptoms of schizophrenia and psychosis in adults. It is commonly referred to by its brand name Modecate.

[18] Aripiprazole is an atypical or second generation anti-psychotic.

the medical team in 2014, when it was prescribed again, because the earlier notes were not available. He again experienced a negative reaction. In February 2014 JK's mother reported that he was 'pulling awful faces with eyes right up and tongue in throat'.

5.37 In June 2014 JK was on three different anti-psychotics (although one was to be phased out), which could have caused difficulties in assessing medication effects and side effects. JK told us he did not know why his fluphenazine was not increased in early 2014 when he was unwell.

5.38 On most occasions JK received his depot injection at the community mental health centre, but if he was not feeling able to leave the house he was visited by a member of the team who administered the injection. In 2016 in prison he was receiving 40mg fluphenazine fortnightly and no oral medication and reported that he felt quite well.

Outpatient appointments

5.39 In 2010 there was a re-organisation of consultant psychiatrists' workplans, so that consultants would be dedicated to either inpatient or community services. Dr A became a full-time inpatient consultant and handed his outpatient case load to a colleague. It appears that there was no case-by-case handover. Dr A's last appointment with JK was in November 2010. He confirmed to the internal investigation that at that time he had no concerns about JK.

5.40 Between 13 January 2011 and 23 June 2014 JK was seen in outpatients by eight different doctors, all of whom were either locum consultants or junior psychiatrists in training. Seven of these doctors saw JK only once.

5.41 The exception to this was the appointments with Dr J when there were some significant changes in his medication and his mother was raising concerns.

5.42 It appears that JK was informed of all appointments by letter.

5.43 There were at least two occasions when the doctor in outpatients proposed possible discharge from the mental health service, and in 2012 the junior doctor wrote to JK's GP to say that the service would discharge him back to his GP's care if he remained stable for the following six months. However it appeared that JK was not keen and said he valued attending every six months or so, and this transfer did not happen. In addition Dr K (the consultant supervising the junior doctors) did not agree with the practice of discharging to primary care anyone with a clear diagnosis of psychosis.

Comment

5.44 JK has said that he found it difficult to talk to someone he did not know about his feelings and experiences. He said that he knew and trusted Dr A but that was not the case with all of the later medical staff, when almost every time he attended out-patients he saw someone different. He told us that he stopped communicating with them as he found it difficult to open up to someone he did not know. He therefore reported that he was fine. He does not think he told them when he felt less well, and he does not remember being asked. There

was some evidence that Dr J had developed more of a therapeutic relationship with him, to the extent that JK contacted him to bring forward one of his appointments.

5.45 This temporary nature of contact with JK would also have been more difficult for the doctors involved as they would have found him less open and less willing to engage. It would have been harder to monitor his treatment, treatment effectiveness and side effects. In these circumstances regular supervision with the junior doctors' trainer would have been particularly important.

5.46 It would have been particularly helpful if he could at this stage have been allocated a care co-ordinator who could have developed a trusting and therapeutic relationship, provided support around his housing, employment and social circumstances and monitored his mental health.

E. Evidence of relapse in early 2014

5.48 On 9 January 2014 JK's mother raised concerns with Dr I (who had not yet seen JK) about his experiencing possible side effects from his medication. She reported that he was rolling his tongue and making other facial movements. Dr I saw him on 13 January 2014 and noted that he had a raised prolactin level[19] and possible tardive dyskinesia[20]. In the light of this it was planned to alter his medication by reducing his amisulpride and later introducing aripiprazole.

5.49 In February 2014 JK's mother again contacted the service to say that JK had reduced his medication further and was 'pulling awful faces' and appeared to be tense and aggressive.

5.50 The following day Dr J saw JK in outpatients. He reported feeling well, had no paranoid thoughts and no thoughts of harming himself or others. It was noted that there was no sign of any relapse.

5.51 At appointments in March and April 2014 it was again noted that JK appeared to be well and mentally stable. However at the end of April JK's mother again contacted the service and reported changes in JK. He had been agitated and could not settle.

5.52 In May 2014 he again appeared to be well and was well-presented, with appropriate speech and behaviour. At this meeting Dr J reported that he and Dr K (his supervising consultant) talked about JK's previous convictions and they were building up a fuller picture. However on 13 June his mother again reported that he had been 'ranting, shouting and believed his mother had poisoned his food'. He had raised his fists to her, but had not hit her. She thought he may have been getting worse for about four weeks. In a telephone call between Dr J and JK he admitted to feeling mildly paranoid and having some thoughts about his food possibly being poisoned. He denied having any thoughts of aggression or violence. The plan was to adjust his medication and review him the following Monday.

5.53 On 16 June at his outpatient appointment JK reported that he had not felt well for two weeks, and had asked for his appointment to be brought forward for that reason. He said he had thought on a number of occasions that his food was poisoned and he had been having some aggressive feelings but was resisting them.

5.54 In the electronic record Dr J noted:

'He has a feeling of "aggressive tendencies" with paranoia and intermittent delusions about food. These are relapse signs for him and had occurred when he assaulted people in the past.'

5.55 He told Dr J that his last violent incident was three years earlier when he assaulted a friend. He said he did not think he was particularly unwell at the

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[19] Prolactin level. Some anti-psychotic medication can cause a rise in a patient's prolactin level. Prolactin is a hormone produced in the brain that is involved in milk production in women and can also be related to growth hormone and other hormone regulation throughout the body.
[20] Tardive dyskinesia is a disorder that involves involuntary movements most commonly of the lower face. It can be caused by longer term treatment with older anti-psychotics.

time. Dr J noted that he had good insight and was aware of his own signs of relapse. The plan was to increase his aripiprazole and to see him again in a week's time.

5.56 On the 23 June, the day before the homicide, JK was again seen by Dr J in outpatients as planned. He reported that he felt better and less agitated since the increase in his medication and had no further aggressive feelings or thoughts of his food being poisoned. It was noted that JK appeared to be 'stable in mental state again'. The plan was to increase his fluphenazine depot medication and adjust his oral medication over time.

Comment

5.57 JK told us that he was actively concealing his symptoms in the weeks leading up to the homicide, so may well have appeared to be better than he was.

5.58 In our view he may not have been detainable under the MHA in June 2014. Dr K, the supervising consultant, has suggested that, with the benefit of hindsight, a family meeting may have been helpful. This would have highlighted the very different opinions on JK's mental health from his mother and himself. He has also suggested that a request for the input of a care co-ordinator may have been appropriate, but that it was unlikely to have happened quickly as the care co-ordinators were under significant pressure with large caseloads.

F. Risk assessment and the transmission of risk information

5.59 There were references to the possible risks that JK may have presented to himself and others from his first referral to the mental health service in many of the entries in records. However there were relatively few more formal risk assessments on file.

5.60 In December 2005 Dr A undertook a detailed mental health assessment following JK's conviction for three counts of assault and the possession of a bladed weapon. He found JK to be extremely suspicious and considered a diagnosis of paranoid personality disorder or paranoid psychotic disorder. He noted that JK was very guarded while talking about his thoughts and feelings. Dr A's plan was to work with the mentally disordered offenders' service and to seek further information from JK's father.

5.61 In May 2006 Dr A wrote another psychiatric report. His opinion was that JK suffered from paranoid psychosis or delusional disorder, rather than paranoid schizophrenia. In his report he recommended a hospital order rather than a custodial prison sentence. A report was written on 3 May 2006 by a consultant psychiatrist attached to the prison mental health in-reach team. In his opinion there was a low risk of harm to JK himself and a low risk of harm to others, based on historical and demographic factors. However he noted that the risk to others would be moderate to high if JK defaulted on his medication. The report also noted that one assault had resulted in a fractured skull to his opponent. However this does not appear to have been recorded elsewhere.

5.62 Once admitted to inpatient care on 5 June 2006 a risk assessment and management plan was partially completed in accordance with the Trust's risk assessment policy. The risk screen noted that JK had a history of violence and aggression and that there was also a current risk. It was also noted that he sometimes believed that his food had been poisoned and that he was under surveillance. He also thought that others provoked him into acting violently. The risk management plan included proposals for reducing stimulation, using one-to-one time and de-escalation and the use of medication as a last resort. Staff also planned to use observation and to develop a catalogue of triggers and early warning signs. A similar form was completed on 17 September 2006. In this document the following triggers and early warning signs were added:

- non-compliance with medication
- irritability and demanding behaviour
- anxiety, pacing and restlessness
- invasion of his personal space
- one-to-one time with nurses.

5.63 This risk assessment and management plan was reviewed in January, February and March 2007. In March it was judged that the risk JK presented to others was low, and it was noted that his contact with his father and sister were protective factors.

5.64 During his admission JK assaulted a number of patients and one member of staff, an occupational therapist (OT) who had taken him out on leave. He said he thought that the OT was 'taking the mickey'. JK's risk to others was assessed as high and he was transferred to the psychiatric intensive care unit for a short period.

5.65 On 9 November 2006 Dr B, a forensic consultant psychiatrist, met JK for an assessment of his diagnosis, risk and management. In Dr B's opinion JK was 'immensely unwell', was guarded and quite flat in his presentation and the risk he presented to others was 'related directly to his mental illness'. The risks posed by JK were as a result of his mental illness and were not personality driven. He believed that JK continued to pose a significant threat to others while he suffered with paranoid delusions and that the threat could be of physical assault or sexual assault, which could be impulsive and without warning.

5.66 On 6 December 2007 JK's second care co-ordinator developed a crisis management plan which identified assaults on members of the public and an increase in paranoid thoughts as relapse indicators.

5.67 In May 2009 JK's third care co-ordinator undertook a risk assessment and developed a management plan. Although significant risk behaviour was noted, it was thought at that time that JK presented a low risk to others as he had been stable for a while.

5.68 The Trust's policy in 2010 on risk assessment and management makes reference to the need for risk assessments to be shared and brought forward: "Recurring themes from these (serious incident) reviews and inquiries have included the need for clinical information to be communicated and shared so

that it follows the patient throughout their treatment" [21]. In addition the policy recognises the significance of transition points in care and states:
"risk assessment, risk management and care planning, must be considered at any ... transition point, to ensure that continuity of care is maintained and information is shared with teams and services who may be involved in providing care to the patient following transition".

5.69 There were, however, a number of points at which such a risk assessment, and risk management plan should have been recorded, but these were absent or were not complete. These are detailed in the following paragraphs

5.70 In November 2010 a risk summary was prepared. The boxes for risk of 'violence, aggression and abuse to the general public', and 'violence, aggression and abuse to staff' were ticked, but at the time he was assessed as presenting a low risk of harm to others or to himself.

5.71 On 15 July 2011 it appears that JK's care co-ordinator, on the day of JK's discharge from his caseload, completed an Assessment, Forensic and Probation proforma on RiO. On this form a number of offences were listed, including:

- 2004 indecent exposure
- 2004 possession of an offensive weapon
- 2005 actual bodily harm
- 2005 assault by beating (a stranger)
- 2005 assault by beating (a friend).

The assaults on other patients and a member of staff when JK was an inpatient in 2006 were not listed.

5.72 In June 2013 a further RiO risk summary was compiled. Much of this risk assessment was blank but the boxes for 'violence, aggression and abuse to the general public' and 'incidents involving the police' were ticked. In this summary it was recorded that JK had a forensic history for assault and carrying an offensive weapon, and that he had had an admission for over 12 months during which he reported that he had assaulted eight people including a member of staff. His overall risk rating for harm to others was however set at 'very low'. It was not clear how this overall risk rating had been determined. The trust's risk assessment policy states that "All items in the Risk Assessment Tool must be completed including free text boxes. If there is no relevant information, this should be indicated." The policy also states that risk information should be shared with all those involved in the patient's care.

5.73 The junior doctors who saw JK in the outpatient department between the first part of 2012 and the first months of 2014 did not complete the progress notes on risk, although they did incorporate some risk assessment into their general monitoring.

5.74 Up to the early part of 2014 it appeared that the focus of his outpatient appointments was his medication and possible side effects, rather than risk factors. When risk was addressed it tended to be to do with suicidal thinking

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[21] *Hampshire Partnership Trust. June 2010. Risk Assessment and Management of Patients/Service Users [Version 2]*

or deliberate self harm, rather than possible harm to others. Similarly there was little focus at that time on his known relapse indicators, including believing that his food was being poisoned and that he was under surveillance.

5.75 Department of Health best practice guidance states: “Structured clinical judgement (in risk assessment) is the approach that offers the most potential where violence risk management is the objective. This approach involves the practitioner making a judgement about risk on the basis of combining: an assessment of clearly defined factors derived from research; clinical experience and knowledge of the service user; and the service user’s own view of their experience”. The guidance also states that risk management should be conducted in a spirit of collaboration and based on a relationship between the service user and their carers that is as trusting as possible.[22]

5.76 On 15 April 2014 JK’s mother contacted Dr J by telephone. She said JK had been very agitated over the last two weeks, and could not settle.

5.77 There was another telephone conversation between Dr J and JK’s mother on 13 June 2014. She told Dr J that that JK had been ‘ranting, shouting and believing she (his mother) had poisoned his food’. He had raised his fist to her in a threatening manner sometimes when angry and he had hit her in the past but not recently. Dr J recorded relapse signs of delusions about food and aggressive feelings towards others and noted that JK had a history of violent assaults when unwell. He contacted JK by phone and arranged an urgent appointment.

5.78 On 16 June 2014 Dr J recorded that JK had described ‘an uneasy feeling that he could be aggressive, but that he doesn’t want to be’. He also described eating in an Indian restaurant ten days or so earlier and thinking his food had been poisoned. JK told Dr J that he was not sure if that was true, and at the time of his appointment he did not think his food was poisoned. He had had some thoughts of harming his parents. He had a further appointment for one week later.

5.79 When JK was seen by Dr J on 23 June 2014 the day before the homicide he denied any ideas that his food was being poisoned, and said he did not have any further aggressive feelings. His medication had been increased and he appeared to be ‘stable in mental state again’.

Comment

5.80 At least two of the doctors who saw JK over the months before the homicide confirmed to the internal investigation that they did not have access to notes from the time before the introduction of RiO. This was significant as most of the more detailed information about JK’s risk behaviour and also information on his previous experience of aripiprazole, was contained in the earlier notes. Indeed Dr K, the consultant who supervised the junior doctors who saw JK said that if he had known his forensic history he would have ‘looked after’ JK himself.

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[22] *Department of Health, 2007 Best Practice in Managing Risk - Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*

5.81 However there was some risk information on RiO, which was neither complete nor detailed, and therefore was not in accordance with trust policy or good practice. This included:

- the incomplete forensic information compiled by his care co-ordinator on 15 July 2011, at the time of JK's discharge from his caseload
- the risk summary, dated 28 June 2013, which identified that JK had been a risk to members of the public and to staff, but gave his overall risk rating as low.

5.82 There was, in addition, an apparent lack of awareness or understanding of his relapse indicators, which appeared to be a feeling that his food was being poisoned and that he was under surveillance. These were identified by Dr J in June 2014 but had not been recorded as such at an earlier date. In one entry violence was recorded as a relapse indicator but it is arguable that violence could be viewed as a **consequence** of relapse rather than an indicator. It seemed that the information that Dr J had about earlier violent episodes had come directly from JK himself rather than from the records.

5.83 There appeared to be no recognition of the potential for increased risk of harm to himself or others at the point of transition in 2010/11.

5.84 In many entries in records there appeared to be an assessment that the risk of violence presented by JK was low while he was mentally well and stable, but that when he was ill the risk was far higher. In his forensic opinion in 2006 Dr B had assessed JK as presenting a significant risk of harm to others while suffering from paranoid delusions.

5.85 There may have been a significant risk to JK's mother during the few months leading up to the homicide. He had strong, but intermittent, suspicions that his food was being poisoned at a time that she was cooking for him two or three times a week.

5.86 It is clear that risk assessment practice between 2010 and 2014 did not accord with trust policy or good practice guidance.

G. Family support and liaison

5.87 There were intermittent links with JK's parents throughout his contact with the mental health service.

5.88 Prior to JK's admission to the department of psychiatry Dr A met JK's father to gather corroborative information. Following his discharge from hospital there are records which indicate that his father had occasional telephone contact with the outpatient department and attended some of JK's appointments with him. Dr A confirmed that he had meetings with JK's father in the outpatient department.

5.89 In early September 2010 there was a note in RiO to say that JK had signed a consent form for information about his care and treatment to be shared with his parents.

5.90 On 16 September 2010 Dr A, JK, his mother and JK's care co-ordinator met at the community mental health centre. JK's mother was told about his mental ill-health, his treatment and possible outcomes. At the time he appeared to be quite well.

5.91 On 13 January 2014 Dr I received a telephone call from JK's mother who reported some concerns about side effects from his medication.

5.92 On 27 February 2014 JK's mother attended a carer's assessment appointment. She raised a number of concerns about her son's care and treatment and about his accommodation and her lack of knowing who to contact in an emergency. Instead of these issues being passed on to the team or her being given telephone numbers to contact, it appears that she was advised to step back a little and encourage JK to be more independent.

5.93 In February 2014 there was a note in the electronic records which recorded a telephone discussion between Dr J and JK's mother. In the note the doctor recorded that he could not locate a recent consent form from JK for him to share information with his mother, but that it would be helpful for her to share information with him, which she did. There was another telephone conversation on 28 April 2014. There were no further recorded carer's assessments.

5.94 In June 2014 there were further telephone discussions between Dr J and JK's mother, in which she told him her concerns about JK's side effects and his disturbed behaviour. JK's mother told us that in the ten days before the homicide he had become more disturbed and believed that the food she cooked was poisoned. It is her belief that the homicide was a tragic inevitability and she cannot understand how this was not spotted by professionals and he was not given the help he needed.

5.95 Although appropriate attention was paid to whether JK had given permission for information to be shared with his parents, it appears members of staff were always willing to talk to his parents and receive information from them. However it appeared that they may then have disregarded this information when JK assured them that he was fine.

Contact with families after the homicide

5.96 In the days following the homicide there were a number of telephone calls and discussions between members of the community mental health team and the mentally disordered offenders team and JK's mother and father to offer support and information. One particular team manager had a number of contacts with JK's mother which she told us she found very helpful.

5.97 Later the panel members of the internal review were told by the police that they could not have contact with the victim's family or members of JK's family, apart from his mother who was not to be a witness at the trial. It was not clear whether the Trust's Being Open policy and procedure (which incorporated guidance on the duty of candour) was closely followed. The procedure refers to the most senior person providing the patient's care and treatment taking the lead in sharing information and support in a meeting with

the family, accompanied where appropriate by a more senior member of staff, possibly the medical or nursing director [23]

5.98 In November 2014 Mr W's son received a letter from the Trust which had been sent by email via Hampshire Police. This letter from one of the Trust's clinical directors had been sent to let the family know of the pending internal investigation. There was an apology for the delay in sending the letter but no offer of help or support.

5.99 The next communication was 11 months later in November 2015 when there was again contact from the police to Mr W's son asking if his details could be passed to the new clinical director for Southampton, to which he agreed. There was then a prompt follow up phone call and a date was agreed for a meeting a few days later to discuss the findings of the internal investigation.

5.100 Mr W's son was given a copy of the report to read and the clinical director also talked it through in some detail. He found this contact helpful and informative, but not particularly supportive. The meeting was used to share and review the internal report after the trial. The clinical director made further offers to keep in contact and to meet the other two brothers but these were not taken up.

5.101 In early December 2015 a further email was sent from NHS England to explain that there was then to be an independent investigation. It was the view of Mr W's son and his brothers that the Trust did not offer any support or assistance to the family. They have pointed out that it was almost six months before they had any contact and 18 months before they saw anyone from the Trust. Instead the family received significant support from Hampshire Police before, during and after the trial.

Comment

5.102 During the last few weeks prior to the homicide there were a number of telephone calls between Dr J and JK's mother. It appeared that Dr J took her concerns seriously and made quite detailed notes of their discussions. However JK then assured Dr J that he was much better. A meeting with JK's mother or a joint session with both JK and his mother being seen together may have been very helpful in identifying the differences in their accounts and further assessing JK's mental health.

5.103 In May 2016 we were given a copy of the Trust's draft Patient Engagement and Experience Strategic Framework 2016/17. This outlines the Trust's aims to work closely and in partnership with service users, family members and the public in all aspects of its services, from individual care planning to service evaluation and development. We understand there will be further guidance on the implementation and practical application of this strategy.

5.104 After the homicide there was some support for JK's family provided by a local service manager. However it appears that there was no timely support for Mr W's family. Clearly there would have been limits on communications with people who were going to be witnesses in the trial. However we are not

[23] *Southern Healthcare NHS Foundation Trust. Being Open Procedure. Version 1 and Being Open Policy Version 1.0*

aware that Mr W's sons would have been witnesses, and it is not clear why there could not have been more contact with them. The Trust's latest policy on the investigation of incidents[24] does not make explicit reference to the need to talk to and support family members, but does refer to the need to adhere to the principles of the duty of candour.

5.105 It appears that the Trust did not at that time have any guidelines on support and information sharing with families (including the families of both the perpetrator and the victim in certain circumstances) following a serious incident. Some guidance could have been very valuable for practitioners and clinicians at such a difficult time. It is possible that the implementation of the Patient Engagement and Experience Strategic Framework 2016/17 may lead to some guidelines.

[24] *Southern Health. Procedure for the Management of Serious Incidents Requiring Investigation. Version 2. March 2016*

6 The Trust's internal investigation

6.1 The Trust conducted a thorough internal investigation which was chaired by an independent expert in mental health investigations. The aims and objectives of this investigation are at appendix D.

6.2 The report contained a summary of the panel's findings and conclusions.

6.3 The panel concluded that JK's care and treatment was disrupted by five separate factors. These were:

- poor care planning and risk assessment practice over time ensuring JK had no care, crisis or relapse plans developed to meet his significant and ongoing needs;
- the failure to develop a Section 117 aftercare package in 2007;
- the introduction of the electronic RiO system in 2010 which failed to carry JK's historic record forward;
- changes to the service model in 2010 - 2011 which led to a disruption in JK's medical management and a long-term lack of medical continuity;
- the decision to discharge JK from CPA in 2011.

6.4 The panel then identified the following contributory factors:

- no medicines management plan and no evidence of education around medication for JK or his family.
- no adherence to Nice guidance.
- a lack of clinical risk assessment and management:
- discharge from CPA and a lack of care planning
- poor referral, transfer and discharge processes
- no section 117 aftercare
- poor documentation and professional communication
- a lack of service user involvement through using a person centred approach
- a lack of carer involvement
- poor policy adherence.

6.5 The panel went on to identify systems failures and overall clinical management as a root cause.

The recommendations arising from the internal investigation

6.6 The Trust should undertake a review of the training of staff and the use of Trust clinical policies and procedures. An audit should be conducted in order to ascertain:

- the extent to which policy non-compliance extends;
- the reasons why policies and procedures are not adhered to.

6.7 The Trust should undertake a review of the briefing/debriefing system for staff and families following major incidents. Trust policies and procedures allow for these briefing to take place, however it would appear that processes are understood poorly and do not occur in a systematic manner.

6.8 The Trust should undertake a review of how Section 117 aftercare arrangements are managed. This should include an audit of:

- the current register;
- the appropriateness and continued relevance of aftercare packages (with particular attention paid to accommodation, independent living skills, employment and socialisation);
- quality of care provided and impact upon recovery.

6.9 A care pathway should be developed to ensure that patients with severe and enduring mental illness are not lost to service and that their ongoing wellness and recovery needs are addressed and adequate monitoring and supervision provided with links to a multidisciplinary team. The pathway should also determine:

- the processes to operate during transitions of care;
- the processes by which continuity of care is ensured and the therapeutic relationship maintained;
- the decision process to establish which patients should be discharged from service;
- how crisis and contingency and long-term follow up will be managed;
- how GP's can be more involved in the management of long-term mental illness;
- how shared care should be used in times of crisis.

6.10 The Trust should review the role of junior doctors in the care of long-term service users and the supervision that they receive.

6.11 The Trust should review the current use of RiO and should also ascertain whether it is practicable to upload vital information from before 2010. To this end an audit should be conducted to ensure:

- that relevant historic information has been transferred to the RiO record;
- that current care and treatment is appropriate in the light of any identified historic context;

- that current care and treatment modes of delivery are appropriate in the light of any identified historic context.

6.12 The Trust should allocate a care co-ordinator to all patients with a diagnosis of psychosis. This is of particular relevance when patients are undergoing a significant change to their antipsychotic medication and/or any significant changes to their care and treatment plans.

7 The Trust's action plan

7.1 The internal investigation made seven recommendations (set out in the previous section). In response to the internal investigation's findings and recommendations the Trust developed a detailed action plan which was included in the internal investigation. At a later date the Trust added in a further six action points which, it was hoped, would be wider ranging and would address the recommendations systemically. The action points and recommendations are set out at appendix E. Many of the action points have been addressed while those which are systemic and process orientated will require considerable ongoing commitment and follow through from all staff and will not be quickly completed.

7.2 We found evidence of that necessary commitment in the leadership and management team for the Southampton area.

7.3 People we spoke to in the Trust were keen to stress that many of the changes outlined here are work in progress. Although there is early evidence of positive changes, there is still a significant amount to be done.

7.4 Some of the recommendations have been and continue to be addressed through the development and implementation of the Trust's 'Southampton Improvement Plan'. It has been acknowledged by the Trust that the Southampton area has had a number of problems over recent years. There were high caseloads, pressure on inpatient and community teams, increased lengths of stay in the inpatients' units, low staff morale, fragmented community teams, many changes in leadership and management, and a high number of serious incidents and complaints. We were told that staff felt unable to review incidents in a constructive way and experienced the process as part of a blame culture. At the time of the homicide staff did not feel safe to talk about their concerns.

7.5 Some of these issues have been resolved and there is now a substantive management and leadership team who are leading on the development of the improvement plan with some early evidence of positive outcomes. Learning networks have been developed in the patch.

7.6 There were three main themes to the recommendations and subsequent action plan:

1. Service and care pathway development and review, including comments on care pathway development, core assessment, section 117, the role of junior doctors, and allocation of care co-ordinators.

2. Learning, particularly from when things go wrong.

3. Support for families and staff after a serious incident.

1. Service and care pathway development and review

7.7 There was a recommendation that the **care pathways** that the Trust are currently developing need to give due consideration to the following:

- the processes to operate during transitions of care
- the processes by which continuity of care is ensured and the therapeutic relationship maintained
- the decision process to establish which patients should be discharged from the service
- how crisis and contingency and long-term follow up will be managed
- how GPs can be more involved in the management of long-term mental illness
- how shared care should be used in times of crisis.
- more consistent risk assessment and the bringing forward of risk information.

7.8 It was also recommended that every service user receiving secondary mental health care should have a **core assessment** incorporating relevant historic information, to include risk, and that for those service users who have been with the service since before 2010 their most recent risk information (previous risk summary, tribunal report or forensic assessment) should be uploaded onto their electronic file.

7.9 The Trust's management of those people who are eligible for **section 117** aftercare should be reviewed. This would include the 117 register, the appropriateness and relevance of aftercare packages, and quality of care. The work on section 117 is being led by the clinical commissioning group and local authority, with the Trust's involvement. It appeared that the Southampton area did not have any section 117 policy during the time that JK was receiving mental health care in the service.

7.10 We were also told that section 117 would be cross referenced with the CPA process but that this has not yet been done. The latest care planning policy[25] appears not to contain any reference to section 117.

7.11 The Trust should review the role of **junior doctors** in the care of long-term service users and the supervision they receive. Prior to any junior doctor leaving a team their current caseload should be subject to multi-disciplinary review. We were told that this has been widely discussed, agreed and implemented. Junior doctors now start their rotation placement with a new caseload, ensuring more opportunities for learning and a greater focus on supervision.

7.12 The Trust should allocate a **care co-ordinator** to all patients with a diagnosis of psychosis. This is of particular relevance when patients are undergoing a significant change to their antipsychotic medication and/or any significant changes to their care and treatment plans. There was evidence that this had been completed, with all patients with a diagnosis of psychosis who meet the criteria for CPA now having a care co-ordinator.

[25] *Southern Health (October, 2015). Care Planning Policy. Version 3.*

7.13 The Trust is working on uploading **risk information** from before 2010 onto its electronic records.

7.14 These recommendations have been incorporated into service developments including the Southampton Improvement Plan. (See appendix F).

2. Learning, particularly from when things go wrong

7.15 One senior manager suggested that there were two issues concerning learning arising from this and other incidents. The first could be considered to be the specific learning for the Trust, teams and individuals arising from a particular review. The second is learning about how the organisation should learn in the future.

7.16 In the view of the Southampton management team the organisation has moved on in its thinking about organisational learning and is now taking a more systemic approach. They described teams working together, in monthly learning hotspots and quarterly learning networks, to identify and begin to address systemic and organisational issues.

7.17 We also heard from the medical director about the processes for the review of, and learning lessons from, serious incidents.

7.18 There was a recommendation that the Trust should review training in relation to policies and procedures and review reasons for non-compliance with clinical policies. The Southampton area manager undertook a review of all training available and identified the need for training on section 117. There was also a review of policy audits including whether they covered compliance. Those audits which did not cover compliance and non-compliance should do so in the future. In addition the Southampton management team are proposing to follow this up, through a focus on specific serious incidents within the Serious Incident Review Panel[26] and links to the further development of policies.

3. Support for families and staff after a serious incident

7.19 There were two recommendations/ action points in this area. The first was a proposed change to the initial management assessment (IMA) template to record and ensure consideration of provision for carers/staff involved. The IMA is the Trust's term for the immediate review undertaken within 48 or 72 hours of a serious incident.

7.20 The second was that the Trust should undertake a review of the briefing/debriefing system for staff and families following major incidents.

7.21 Staff support and de-briefing is available for staff and teams through the Trust's Critical Incident Stress Management (CISM) service. It is operated by colleagues who offer this service in addition to their normal 'day jobs'.

7.22 The statutory duty of candour in the NHS became a Care Quality Commission standard for all organisations on 1 April 2015. This requirement, therefore, did not apply to Southern Health at the time of this incident, but would apply if a comparable incident were to occur today.

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[26] *There is a Serious Incident Review Panel in each division. Each panel reports to the Corporate Serious Incident Assurance Panel.*

7.23 The action plan recorded that the Trust had from 2014 a policy and procedure on the statutory duty of candour[27], and training has been undertaken within the Trust. We have been given copies of both the policy and procedure and in our view they are comprehensive and detailed. A further updated duty of candour policy and a number of background leaflets and step-by-step guides[28] were posted on the Trust's website in May 2016.

7.24 In relation to support for families and carers The Trust's incident management system, Ulysses, has a mandatory section for all incidents relating to moderate or high harm when an incident is reported. We were told that it is now Trust practice to identify a lead contact for the family to offer support and information as soon after the incident as possible. This may be undertaken by the investigating officer, a senior member of Trust staff or by someone they may already know.

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[27] *Southern Health. September 2014. Duty of Candour Policy and Duty of Candour Procedure.*
[28] *Southern Health. Duty of Candour Policy. Version 3. May 2016.*

8 The independent investigation's commentary on the internal investigation

The independent investigation's findings

8.1 The Trust's internal investigation appeared to have been very thorough and detailed. Many of the staff who had cared for JK over the years were interviewed and their interviews were transcribed and checked. The team also scrutinised policies and other documents. All of the documents used by the internal review were made available to this independent investigation. The internal review panel appeared to have been well supported and resourced by the Trust.

8.2 We are broadly in agreement with the internal review's main findings, contributory factors and recommendations. However, while there were a number of significant gaps and deficiencies, we believe some aspects of JK's care were not very different from what would have happened in other Trusts. Some of the gaps have been identified by the Trust and the internal and independent investigations with the benefit of hindsight and awareness of the outcome. Many of the people providing care and treatment demonstrated commitment and caring, and recognised the importance of reflection and learning from this tragedy.

If JK had been a patient in the service in 2016

8.3 We were told that JK would definitely meet the criteria for CPA if he were a service user in 2016. The Trust's CPA guidelines[29] appear to confirm that that is the case. He would therefore have had a care co-ordinator allocated to his care for as long as he remained in the service thereby providing continuity and consistency. There would have been regular CPA reviews, jointly with his care co-ordinator, his consultant and others involved in his care. If he was having his first episode of psychosis in 2016 he would have met the criteria for the early intervention service. There would have been a greater focus on his accommodation, employment and social circumstances, and he may have been offered psychological intervention and, with his agreement, family meetings, which may have included discussions on medication and signs of relapse. If he had an admission on section 3 or 37 of the MHA his name would have been put on the section 117 register.

He may have been followed up in a practitioner-led clinic. He would also have been able to access the Recovery College [30]. In addition he would have a risk assessment on his electronic file and this may have been shared with him, so that he too would be aware of his risks and involved in their management. Guidance on safety plans for those who present possible risk behaviour is currently being developed. There would have been a rapid response to any early indication of relapse, possibly using shared care, so that he would have had greater input in the community.

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[29] Southern Health Care Planning & Care Programme Approach-Standard Operating Procedure Mental Health Division. January 2010. To be reviewed in December 2016.

[30] The Recovery College is funded by the Trust to provide courses for service users and staff to equip them with the knowledge and skills to get on with their lives. Courses are on wellness, recovery, self-belief, care planning etc.

9 Further contributory factors (additional to those in the internal investigation report)

9.1 This independent investigation has identified a number of additional contributory factors and recommendations for the Trust. All these contributory factors and recommendations relate to the organisation's systems and processes and do not constitute any criticism of any individual practitioner.

9.2 The contributory factors:

- No continuity in those providing JK's care from the end of 2010, so that there was a lack of knowledge of JK as a person and of his mental ill-health.
- A lack of recognition of JK's specific relapse signs or discussion with him or his family on these, and therefore no systematic use of his relapse signs/indicators to review his mental health.
- Limited ongoing dialogue with family members about JK's mental health. Some discussion with JK's mother in the weeks before the homicide, but no triangulation through a meeting with her or with her and JK.

Comment

9.3 Some of our additional recommendations have arisen from our review of JK's care and treatment, while others are in response to this investigation's terms of reference which require us to "review the Trust's past (i.e. in place in July 2014) and present family and carers engagement policy for serious patient incidents (including homicide) against best practice and national standards, especially the legal and contractual duty of candour."

9.4 The NPSA good practice guide[31] states:

"When an incident leading to serious harm or death occurs, the needs of those affected should be of primary concern to the Trust ...... Any contact should be undertaken in a respectful, dignified and compassionate manner, and in a spirit of openness. A designated senior individual, with the appropriate skills and experience, at the Trust (in the most serious incident, for example homicide, likely to be at Board level) should take the lead, and agree with the family who the main family contact will be."

9.5 According to the Trust's current policy[32] the internal investigation should have proceeded to the Divisional Serious Incident Review Panel and from there to the Corporate Serious Incident Assurance Panel, which reports to the Quality and Safety Committee (QSC).

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[31] *National Patient Safety Agency (2008) Independent investigation of serious patient safety incidents in mental health services.*

[32] *Southern Health Procedure for the Management of Serious Incidents Requiring Investigation. March 2016.*

9.6 It appears that the Trust Board, including the non-executive directors, did not review the details of the internal report within a Board meeting. Nor was the report reviewed by the QSC, which is the committee of the Board which has the lead for clinical governance, and has three non-executive director members. Our review of written reports and minutes of Board public meetings has found the following:

9.7 There was a brief mention of the homicide in the medical director and director of nursing's joint written report on 29 July 2014 and a reference to the homicide being reported to Monitor and the CQC. In the same meeting the performance report referred to two possible homicides and stated "thematic reviews have found no immediate systemic issues arising from these cases". It appears from the minutes of the meeting that this homicide was not discussed.

9.8 The next reference to the homicide appears to have been twelve months later in the meeting of 28 July 2015 when the Director of Mental Health and Learning Disability informed the Board that there was to be an independent investigation into the perpetrator's care and treatment. The director wished the Board to be aware of this as soon as possible. There was no indication that the internal report had been discussed at a Board meeting at that time.

9.9 At the Board meeting on 1 December 2015 it was reported that Niche Patient Safety would carry out the independent investigation and that the initiation meeting had taken place. In the minutes of this meeting one of the non-executive directors enquired how Board members could be kept informed of the investigation's progress. It was agreed that there would be a review of how the Board could have 'appropriate visibility of issues which might require escalation' and that the medical director would keep the Board informed of this specific investigation. At the Board meeting on 23 February 2016 it was agreed that both of these action points were now closed, as Board members had been updated through the weekly Board briefing. This Board briefing, sent out by email, gave more details of the independent investigation and a summary of the findings of the internal investigation.

9.10 It is stated in the notes of the Corporate Assurance Panel meeting on 2 March 2015 that there would be a Board to Board (commissioner and Trust) meeting to discuss the report. However the commissioners, as organisers of this meeting, were unable to find a suitable date and it was then agreed to have a single Board representative from each organisation. The medical director attended this meeting.

9.11 It is clear that there were references at different times to this serious and tragic incident within Board reports and minutes. However there appears not to have been any Board level scrutiny of the details of the incident or of the internal investigation. Further it appears that non-executive directors asked how they would be informed about the independent investigation, suggesting that this was not the usual practice.

10 Predictability and preventability

10.1 In its document on risk, the Scoping Group of the Royal College of Psychiatrists observed that:
"Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is never possible for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour."[33]

10.2 Similarly, the Trust's risk assessment policy states:
"Risk assessment is an assessment of a current situation, not itself a predictor of a particular event. Although accurate prediction is never possible in individual patients, some negative outcomes can be reduced in frequency by sensible contingency planning."

10.3 The National Confidential Enquiry reports that, in England, there was an average each year of 34 convictions for homicide of people with schizophrenia (or other delusional disorders) who have been in recent contact with secondary mental health services. More than half of the perpetrators were not adhering to their medication or had missed their last contact with the mental health service.[34]

10.4 At the court case in 2015 JK was found guilty of murder and was given a life sentence with a 20 year tariff. Two forensic psychiatric reports were presented to the court, one commissioned by JK's defence team and the other by the Crown Prosecution Service. The psychiatric reports had different perspectives on whether the assault on Mr W was a result of, or exacerbated by, mental illness or whether it was potentially perpetrated by someone not suffering from any significant mental ill-health at the time. The verdict of murder would suggest that the jury were of the latter view.

10.5 One of this investigation's terms of reference was to consider whether this homicide was predictable or preventable. JK had a significant history of violence and most instances of assault appear to have been associated with his early presentation of psychotic illness or with subsequent relapses. The forensic psychiatrist's assessment when JK was in hospital in 2006 was that "he continued to pose a significant threat to others while he suffered with paranoid delusions and that the threat could be of physical assault or sexual assault, which could be impulsive and without warning".

10.6 In our judgement it was predictable that there would be some violent episode at some point in the light of JK's history, and his tendency to conceal his relapses; but the timing, nature and severity of this violence was not

[33] *Royal College of Psychiatrists (2008) Rethinking risk to others in mental health services. Final report of a scoping group. p23.*
[34] *University of Manchester. October 2016. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Making Mental Health Care Safer: Annual Report and 20-year Review.*

predictable. Further, there may have been a significant risk to his mother at the time of his relapse in June 2014 as he was having a great deal of contact with her and she was cooking his dinner twice a week. He had delusions that his food was being poisoned and this could have put her at significant risk.

10.7 There may have been opportunities to change and improve the provision of care in response to JK's relapse, and possibly prevent a violent episode, if a number of factors had been different. These factors included:

- Not transferring significant risk information onto the new electronic records system in 2010
- Gaps in the recording and communication of comprehensive risk assessments between 2010 and 2014, so that he was assessed as low risk in the incomplete risk assessments which were recorded, and remained in the care of junior doctors rather than the consultant
- An absence of the sharing of information and triangulation between the mental health service, JK and his family
- An over reliance on changes to his medication and less attention being paid to his relapse indicators, relationships and social circumstances.

10.8 In summary, in our judgement, it was predictable that there could have been a violent episode, but not that this would have resulted in a death. The violence might have been preventable if the risk assessment and management plan had been more robust, resulting in better care and treatment for JK.

10.9 As the Royal College of Psychiatrists has observed "accurate prediction (of risk behaviour) is never possible for individual patients" but services may be improved for all those with mental health problems by learning lessons and implementing recommendations. Our recommendations are therefore made with this purpose in mind.

11 Recommendations

11.1 Having carefully considered the findings of the internal investigation and our own investigation, and our review of how the Trust followed up the internal investigation's recommendations, we have developed six recommendations. We urge the Trust to put these recommendations into practice through action planning, service development, policy and guideline development, training, supervision and clinical audit.

Recommendation 1:
The Trust's care pathways should give due prominence to the importance of having one or two key members of staff who can provide continuity of care for a long-term service user.

Recommendation 2:
The Trust should adopt and more closely follow the NICE schizophrenia quality standards[35] and the Royal College of Psychiatrists' good practice guide[36] particularly in relation to risk assessment and risk management, family education and support, relapse indicators, social circumstances, engagement and psychological interventions.

Recommendation 3:
The Trust should develop a policy and practice guidance on family engagement during an episode of care (including possible family meetings).

Recommendation 4:
The Trust should develop guidance on family support and access to information after a serious incident, to include guidance on implementation of this and the Duty of Candour policy.

Recommendation 5:
The Trust should ensure that the lead for liaison with family members and carers after such a serious incident should be at executive director or equivalent level, in accordance with the NPSA good practice guidance. This director would not necessarily carry out all contacts but would make the initial contact and would guide the continuing support and information sharing.

Recommendation 6:
The Trust should ensure that future reports and recommendations following a particularly serious incident should be formally reviewed and discussed by the Trust's executive and non-executive directors.

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[35] *NICE. Psychosis and schizophrenia in adults. February 2015. https://www.nice.org.uk/guidance/qs80*

[36] *Royal College of Psychiatrists .August 2016. Assessment and management of risk to others. Good practice guide. http://www.rcpsych.ac.uk/pdf/CR201GPGx.pdf*

Appendix A

Purpose and terms of reference of the investigation

11.2 To identify whether there were any gaps, deficiencies or omissions in the care and treatment that JK received. The investigation process should also identify areas of best practice, opportunities for learning and areas where improvements to services might be required which could help prevent similar incidents from occurring. Having assessed the quality of care provision, the investigation should make a judgement as to whether the incident that occurred on 24 June 2014 could have been predicted or prevented.

11.3 The outcome of this investigation will be managed through corporate governance structures in NHS England, clinical commissioning groups and the provider's formal Board sub-committees.

Terms of reference

1 Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

- If the investigation satisfied its own terms of reference
- If all key issues and lessons have been identified and shared within the relevant organisations
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
- Review progress made against the action plan and any other relevant organisational action plans
- Review processes in place to embed any lessons learnt within the organisation and progress of embedding change.

2 In light of the above review, and contact with both the victims and perpetrators families, the investigation team should comment on the assessment, treatment and care that JK received from Southern Health NHS Foundation Trust from his first contact with services in July 2004 up to the time of the incident on 24 June 2014.

3 Having assessed the above, to consider if this incident was predictable or preventable and comment on relevant issues that may warrant further investigation.

4 To assess and review any contact made with the victim's and/or perpetrator's families by the Trust since the completion of the internal investigation.

5 To review the Trust’s past (i.e. in place in July 2014) and present family and carers engagement policy for serious patient incidents (including homicide) against best practice and national standards, especially the legal and contractual duty of candour.

Level of investigation

Type C: an investigation by a single investigator examining a single case (with peer reviewer).

Appendix B

Medication

Over the ten years of his contact with services JK had the following prescribed medication:

Date	Medication	Notes	Mental state
July 2004	Risperidone 4mg once daily		
November 2005	Risperidone 2mg once daily		
March 2006	Risperidone 4mg once daily	appeared to be taking only 2mg.	
June 2006 (on ward)	Risperidone 4mg	Thought to be not taking his meds. Plan to change.	Hospital order following assaults
25 July 2006		Told staff he would consider having a depot, but this was not prescribed.	
27 November 2006		Forensic consultant recommended olanzepine and if that not effective consider clozapine (although JK not keen).	
18 April 2007	Amisulpride 400mg morning and 600mg at night	Discharged from ward. Noted that eligible for section 117 aftercare.	Appeared to be stable.
			Appeared unkempt. Possible negative symptoms.
12 March 08	Aripiprazole 10mg every morning	JK had stopped medication for three months. Change of medication.	Relapse
6 May 2008	Plan to recommence amisulpride and stop aripiprazole.	JK requested change in medication. Said aripiprazole made him feel panicky.	Relapse
10 Oct 08			Panic attacks. JK had run out of meds four weeks earlier.
19 January 2009	Amisulpride increased to 400mg twice daily and short course of diazepam.		Mental health had deteriorated.
23 January 2009	Continue amisulpride and taper off diazepam.		Mental health improving. Later in March reported that he was too paranoid to go out.
27 August 09	Amisulpride 800mg twice a day	1.6mg above BNF max but effective. Agreed with Dr A to take drugs indefinitely	Appeared to be stable.

21 May 2010	Had commenced on fluphenazine (Modecate) 25mg fortnightly. Amisulpride 800mg twice a day		Appeared to be stable.
16 Sept 2010	fluphenazine three weekly, and amisulpride 800mg twice daily.		Appeared to be fairly stable.
ongoing	fluphenazine three weekly continued.		
9 January 2014		Mother contacted team to say that she thought he was getting side effects from medication, rolling his tongue and other facial movements	
13 January 2014		Raised prolactin levels and possible tardive dyskinesia	Appeared to be fairly well mentally.
17 January 2014	Amisulpride reduced to 600mg twice daily. Plan to introduce aripiprazole.		No evidence of any relapse.
17 February 2014		Mother phoned to say she thought he had reduced his medication more than had been recommended and that he was continuing to have facial side effects ('gurning').	
18 February 2014	JK said he had been taking 800mg twice daily. Plan to continue on amisulpride 800mg twice daily and fluphenazine 20mg fortnightly.	There is reference in the notes to say that Dr J was referring to Maudsley guidelines when considering a possible change.	Reported feeling very well.
24 February 2014		Proposal was to reduce amisulpride or switch to aripiprazole.	
18 March 2014	Reduce amisulpride to 400mg once daily.		Appeared to be stable.
15 April 2014	Reduce amisulpride to 200mg once daily.		Appeared to be stable.
28 April 2014		Mother phoned to say he had been very agitated and could not settle.	
23 May 2014	Commence aripiprazole 5mg daily. Plan to stop		Appeared to be stable.

	amisulpride at next review.		
13 June 2014	Phone call to JK advising him to increase aripiprazole.	Telephone call with JK's mother. He had been 'ranting and shouting' and thought she had poisoned his food. Had been getting worse for four weeks. Had raised his fists at her.	Reported feeling 'mildly paranoid'. Denied any violent thoughts.
16 June 2014	Current meds: Fluphenazine 20mg fortnightly Amisulpride 200mg daily Aripiprazole 10mg daily Plan to increase aripiprazole to 20mg and continue with amisulpride 200mg but double the dose if JK became distressed.		Relapse Not well for past two weeks. Feelings that his food was being poisoned for ten days.
23 June 2014	Plan to increase fluphenazine to 30mg fortnightly and continue aripiprazole 20mg daily and amisulpride 200mg daily until fluphenazine was 'steady state'.		No more thoughts of food being poisoned. Said he felt better and less agitated.

Appendix C

Number of psychiatrists involved between 2011 and 2014

Psychiatrist	Dates seen	Dates did not attend
Dr C (locum consultant)	13 Jan 11	
Dr D (locum consultant)	14 April 11	14 July 11
Dr E (locum consultant)		22 Sept 11
Dr F (locum consultant)	22 Nov 11	9 March 11
Dr G (trainee psychiatrist CT1)	29 May 12	
Dr H (trainee psychiatrist CT3)	20 Feb 13	
Dr I (trainee psychiatrist CT3)	13 Jan 14 (following this appointment Dr P discussed JK's medication with Dr K, consultant)	21 Aug 13, 23 Oct 13
Dr J (trainee psychiatrist CT3))	18 Feb 14, 18 March 14, 15 April 14, 23 May 14 (with Dr K, consultant) 16 June 14 (this appt was brought forward at JK's request) 23 June 14	
Dr K (supervising consultant for junior doctors)		

Appendix D

Aims and objectives of the Trust's internal investigation

To provide an objective external managed investigation, to establish the facts of what happened in the care and treatment provided to P1. This will include but not be limited to, establishing whether failing occurred in care or treatment, to look for improvements rather than to apportion blame, to establish how recurrence may be reduced or eliminated,

Purpose and scope of the Investigation
To review the events and the care provided to P1 to identify the root causes and the key learning from this incident and use this information to significantly reduce the likelihood of future harm to patients.

The scope of the investigation will include an overview of P1 involvement with mental health services concluding with the outcome for him following the incident on **24 June 2014**.

This should include a review of all associated clinical records, as well as interviews with a range of individuals to include: D3, D4. The purpose of the investigation is to:

1. To establish the clinical risk management and clinical care of P1, comparing this to the 'best practice' reflected within national and local guidance/ pathways for community care.
2. To establish if the risk assessment and risk management of the patient was sufficient in relation to their needs and the risks presented in the management of their condition.
3. Whether the assessment, planning and implementation of care delivered to P1 was of the standard expected by the organisation as per which Southern Health NHS Foundation Trust policies.
4. Whether the assessment, planning and implementation of care delivered to P1 was of the standard expected by relevant professional bodies NMC and GMC.
5. Whether the assessment, planning and implementation of care delivered to the above in any way contributed to the incident.
6. To interview staff / clinicians involved in the patient's care to ascertain their views on the patient's risks and the risk management plan.
7. If possible to ascertain the views of P1 and his parents in relation to their care, based on the input that the family/patient wishes to have, using advocacy services if required.
8. To review how learning out of concerns from any previous similar incidents has been embedded in practice and informed care practice and safety.

9. To review all clinical records including risk assessments and risk management plans, clinical assessments and care plans, demonstrating the reason for admission; the assessment and treatment plans and the expected outcome for the patient, providing a clear chronological time line of P1 journey through services following their admission.

10. To review the reason for admission, through documentation and interviews (Staff and patient/patient's family) and to establish the appropriateness of admission, care planning and treatment plans.

11. To interview staff/ clinicians involved in the patient's care to ascertain their views on P1 and the decisions related to their time on the unit.

12. To review the leadership and management of Southampton Community Treatment Team (CTT), to determine it as being of the standard expected of the organisation, especially in regard to patient quality and safety.

13. Whether there are any underlying issues which may impact on how the CTT team on functions, and consequently affect patient care.

Appendix E

Southern Health’s action plan

11.3..1 Southern Health's action plan. One action point, arising from another investigation, (3) has been removed.

	Date:	***Produced by: (Name & Job Title)***			
Issue No.	**Action/s to be taken**	**How will completion of the action be evidenced**	**Date action must be completed**	**Action Progress**	**Notes/ Further information**
1	Using JK case, action learning set to be facilitated by an external facilitator which explores JK's care and treatment referencing key policy guidance. Key staff to be invited to attend.	Completion of learning set	end of Mar 2015	complete	Action learning set completed and discussion took place in SIRI Panel. Action Learning set included reflections on policy use which will be fed into the development work on policies this year - such as the disengagement policy.
2	Proposed change to IMA template for review to ensure the IMA author considers provision for carers/staff involved and referral to CISM if appropriate.	For Area Lead Nurse to discuss with Associate Director of Nursing, AHP & Quality- MH, Social Care & LD	end of Mar 2015	complete	IMA template includes section on support for carers and support offered for staff. Duty of Candour is now included in the incident reporting system and family involvement is considered through SIRI process under duty of candour. In Southampton we are able to check support offered to family through the IMA and 48 hour process. The IO will also meet with the family to offer support and the senior team offer to meet with families if helpful

4	The care pathways that the Trust are currently developing need to give due consideration to the following: • the processes to operate during transitions of care; • the processes by which continuity of care are ensured and the therapeutic relationship maintained; • the decision process to establish which patients should be discharged from service; • how crisis and contingency and long-term follow up will be managed; • how GP's can be more involved in the management of long-term mental illness; • how shared care should be used in times of crisis.	Area Manager and Clinical Services Director to take to divisional service Board for information and to cascade	End of November 2015	complete	This action has been superseded by the Southampton Improvement project as evidenced in recommendation 4 below. Attached also details how the learning from this incident has been linked to the improvement plan
5	Prior to any junior doctor leaving a team their current caseload should be subject to multi-disciplinary review.	To be disseminated via consultant meeting	end of Mar 2015		Completed at Consultant meeting July 2015 - wider learning is that trainees no longer 'carry over' their caseload - they start with a new caseload which ensures clients are reviewed by the Consultant and/or MDT when one Junior Dr leaves
6	Community Treatment Team (CTT) to ensure that every service user receiving secondary mental health care will have a core assessment incorporating relevant historic information, to include risk.	Completion of core assessment for all service users receiving secondary mental health care	end June 2015 **To be updated to end of December 2015**		Core assessment is completed for all clients, however, process underway to ensure this includes historic risk information by uploading the most appropriate and helpful information to RiO and referencing that in the progress notes. This may be the previous risk summary, tribunal report, forensic assessment. We are reviewing every client who was with us prior to RiO being introduced to see what historic risk information they have available and then reviewing their paper notes to upload required information.

7	Review of allocation of care co-ordinator for all service users with a diagnosis of psychosis.	CTT to undertake and complete a review of all service users with psychosis who do not currently have a care co-ordinator to determine if the criteria are met for allocation of care co-ordinator.	end of July 2015 **To be updated to end of November**	Complete	Complete - all clients with a diagnosis of psychosis have been reviewed, where this is no CCO it has either been confirmed that they do not require a CCO as they do not meet the criteria for CPA or their CCO has been confirmed. Not everyone with a diagnosis of psychosis will meet the criteria for CPA; some may be stable but require a period of support and review before transferring back to the GP. We are working with GP colleagues regarding shared prescribing of anti-psychotic medication. JK would meet the criteria for CPA now if he were being seen by our services and would have had a CCO.
R1	The Trust should undertake a review of the training of staff and the use of Trust Clinical policies and procedures. An audit should be conducted in order to ascertain: · The extent to which policy non-compliance extends; · The reasons why policies and procedures are not adhered to.	To establish what training is available and agree any further training needs. To establish which audits are already undertaken and review reasons for failure re: compliance.	01-Sep-15	Complete	Review completed - 117 training currently being developed
R2	The Trust should undertake a review of the briefing/debriefing system for staff and families following major incidents. Trust policies and procedures allow for these briefings to take place, however it would appear that processes are understood poorly and do not occur in a systematic manner.	Provide narrative about Trust duty of candour – KW	14-08-15	Complete	Complete
		Evidence that debriefing and CISM are used appropriately in the division	14-08-15	complete	Complete - issue of update identified
		Evidence about use of weekly diffusion sessions in Antelope	04-08-15	Complete	Complete - see attachments

		Develop debrief procedure for staff to include antelope diffusion sessions for division	28-08-15	Complete	Shared at Acute Care Forum on 18/02/2016
R3	The Trust should undertake a review of how s.117 aftercare arrangements are managed. This should include audit of: The current register The appropriateness and continued relevance of aftercare packages Quality of care provided	development of s.117 policy High cost placement panel to agree process for ensuring timely reviews are implemented and brought back to panel	01-10-15	Overdue	CCG is working on this with support from our SHFT MHA lead We are also working with high cost panel colleagues on a flowchart to explain the process to CCOs. All our team managers have received training on the process and we have a new process to ensure managers are aware of who is being presented at panel and any actions from it 117 review is also now included in the CPA process

R4	A care pathway should be developed to ensure that patients with severe and enduring mental illness are not lost to service and that their ongoing wellness and recovery needs are addressed and adequate monitoring and supervision provided with links to a MDT. The pathway should also determine: • the processes to operate during transitions of care; • the processes by which continuity of care are ensured and the therapeutic relationship maintained; • the decision process to establish which patients should be discharged from service; • how crisis and contingency and long-term follow up will be managed; • how GP's can be more involved in the management of long-term mental illness; • how shared care should be used in times of crisis.	Locality manager to establish what work has been completed to date as part of the Southampton improvement plan in relation to this learning and to ensure the recommendations are fed into the more detailed pathway development	Dec-15	Complete	Implemented on 23 November - document outlines the changes and how they link to the learning from this and other incidents
		provide evidence of learning and action within the division		Complete	The Southampton improvement programme brought the services in line with other areas across the Division
R5	The Trust should review the role of Junior Doctors in the care of long-term service users and the supervision they receive			Complete	Discussed at Consultants meeting in July 2015 and steps to review CT caseloads underway. Confirmation this has happened in the North West and East

R6	The Trust should review the current use of RiO and should also ascertain whether it is practicable to upload vital information from before 2010. To this end and audit should be conducted to ensure: • That relevant historic information has been transferred to the RiO record; • That current care and treatment is appropriate in the light of any identified historic context; • That current care and treatment modes of delivery are appropriate in the light of any identified historic context.	Agree clear plan for review of all Southampton clients with the service since 2010 to ensure historic risk information is available on RiO	End of December 2015	Begun & On Track	Process underway to ensure historic risk information is added to RiO for anyone who was with our services prior to the introduction of RiO, by uploading the original assessment letter, tribunal report, first risk assessment and most recent risk assessment prior to RiO being introduced is underway
		Outline steps that were taken by the division at time of RiO transfer in 2010		Complete	The West Area and North underwent a process to transfer all clinical historical information onto RiO The East are taking this issue to their IG meeting to consider how learning from this incident can be applied across the areas
R7	The Trust should allocate a care coordinator to all patients with a diagnosis of psychosis. This is of particular relevance when patients are undergoing a significant change to their antipsychotic medication and/or any significant changes to their care and treatment plans. Agreed actions needs to apply to those who meet CPA criteria.	CTT to undertake and complete a review of all service users with psychosis who do not currently have a care co-ordinator to determine if the criteria are met for allocation of care co-ordinator.		Complete	As above - all patients with a psychosis diagnosis have been reviewed and either have a CCO or do not meet the criteria for CPA

Appendix F

Outline of Southampton Improvement Plan

Meeting date	2 December 2015
Report title	Southampton AMH services: Pathway Improvements

1 INTRODUCTION

It was identified that the Adult Mental Health services for people in Southampton currently provided by Southern Health NHS Foundation Trust were not of the standard we would expect for people who use our services. In order to address this we have developed an improvement plan with the team in Southampton.

We have been working with our staff, service users and partners to identify the issues we want to improve.

We have also taken learning from Serious Incidents in Southampton, many of which have identified similar root causes.

The purpose of this report is to provide an update on the improvements being made and outline how learning from serious incidents has been used to make improvements.

2 SOUTHAMPTON ADULT MENTAL HEALTH SERVICES

There were a number of indications that Mental Health Services for people in Southampton were not of the standard we would wish for people who use our services. These indications were:

- Quality and safety issues as identified through higher than national averages of SIRIs and complaints
- Staff wellbeing as identified through higher numbers of vacancies; staff turnover and sickness
- High number of interim roles within senior management positions leading to uncertainty and lack of continuity in terms of delivery of key quality and performance indicators.
- Delivery of key performance indicators (KPIs) specifically around CPA compliance and waiting times being poor
- High caseload numbers within Community Treatment Team (CTT)
- Disjointed provision of crisis services across the area – in that 'crisis' functions are currently being provided by Access and Assessment Team (AAT) CTT and Hospital at Home (HAH)
- Above average length of stay and readmission rates within the inpatient unit.
- Inconsistencies within the Southampton Clinical Pathway compared to the other two AMH areas in terms of team names; functions and

processes
- Concerns and complaints raised by people who use our services
- High levels of restrictive practices such as seclusion and restraint
- Concerns raised by the local Clinical Commissioning Group around the quality and perceived lack of access to mental health services in Southampton

IMPROVEMENT

In order to rectify the issues with services in Southampton an improvement team was identified to support the services and a plan was created to bring about positive changes.

The improvement team along with the Southampton management team spent time reflecting on the root causes of the issues and identified the following issues:

- A lack of consistent leadership
- A fragmented community pathway with eight separate teams available to provide different functions of care
- A confused crisis pathway with two teams delivering different functions of the pathway
- High caseload numbers across the pathway
- A lack of a clear pathway for people with Borderline Personality Disorder
- Some cultural issues within the area with teams working in silos and not feeling valued or supported
- High levels of demand and acuity
- A complicated process for managing complaints and incidents which led to an industry of action plans not focussed on true learning and embedding of change

In order to address these issues the improvement team developed a plan of action to achieve improvements. The improvement plan is attached for your information but the main components of change are:

- A redesigned community pathway, returning to a Community Mental Health team delivering all functions of community care, based in the local area they serve (East, West and Central Southampton) more closely linked to Primary Care.
- A redesign of the Crisis pathway so there is one 24 hour team available seven days a week to support people who are acutely unwell and either help them towards recovery at home or in hospital with more capacity.
- Increase the working hours of the Psychiatric Liaison service at Southampton General Hospital Accident and Emergency department
- Improvements to the pathway for people who are in hospital with more regular reviews of patient need and closer working between community and inpatient colleagues to ensure people don't stay in hospital any longer than they need to and there are local beds available for local people
- A redesigned leadership structure with a permanent Area Manger and the introduction of a Head of Nursing to lead on patient safety, learning, reducing restrictive practice, quality compliance, nurse leadership and

practice development.
- Investment in leadership development, reflective practice, staff drop in sessions, improved communication between senior management and front line staff
- A redesign of the process for investigating serious incidents: the Clinical Services Director takes a lead on reviewing all serious incidents with the Area Manager to ensure leaning is clinically led and immediate risks are identified and mitigated against
- A new process for learning is being developed with quarterly learning networks being implemented where teams will bring a case they wish to share learning from with one another and regular learning newsletters being produced
- Improved links with stakeholders and partner organisations; a stakeholder event has been held with another being planned to ensure our stakeholders are aware of the changes being made and invited to comments on improvements to be made
- Improved contact with service user groups, IAPT, Child and Adolescent Mental Health Services, Accident and Emergency, police colleagues, Domestic Violence colleagues, HealthWatch and third sector colleagues

LEARNING FROM INCIDENTS

The first phase of the improvement plan; the redesign of services was implemented on 23 November 2015. In order to inform the redesign we completed a thematic review of learning from serious incidents and included this within the development of the pathway. Common themes from serious incidents in Southampton are:

- Multiple transitions between different teams
- Delay in accessing treatment
- Lack of joined up working
- Poor communication with Primary Care
- Lack of risk management
- Lack of support when leaving hospital
- Lack of continuity across the pathway
- Lack of crisis planning

The redesign of services will address the following areas:

What	***How***
Multiple transitions between different teams	Fewer teams and fewer transitions
Delay in accessing treatment	Increased capacity in community teams and work to reduce caseload size and implement safer caseload management process

Lack of joined up working	Fewer number of teams involved in care and requirement for transfer between teams to be via conversations between practitioners
Poor communication with Primary Care	Community Mental Health Teams more closely linked with their local GP, aligned to the GP clusters, with identified Consultants for specific GP practices
Lack of support when leaving hospital	One 24 hour 7 day a week team to support people leaving hospital and two practitioners each day in the CMHTs available for more intense support

MONITORING

The improvement team meet weekly to review progress and ensure the agreed actions are achieved. The team monitor their progress against a set of key performance indicators, such as; serious incidents; restrictive practices; complaints; staff turnover and sickness; out of area bed use, length of stay; waiting times.

These performance indicators are then shared with the Adult Mental Health Service Board and the Executive Board for the Trust to ensure progress is monitored and the Trust have oversight of the quality indicators which we are hoping to improve.

The team are already seeing positive results such as a reduction in restrictive practices (seclusion and prone restraint), reduction in Serious Incidents, more people receiving their care planning review and reduced length of stay. However, the team expect the improvements to take up to two years to be fully realised and continued attention, assessment and learning will be needed in Southampton to ensure the positive improvements are embedded.

Appendix G

Southern Health NHS Foundation Trust

The Trust provides community health, mental health and learning disability services for people across the south of England, including Hampshire, Dorset, Oxfordshire and Buckinghamshire.

There are around 9,000 members of staff across more than 200 sites, including community hospitals, health centres, inpatient units and social care services.
The Trust's services include:

- Mental health services - treatment and support to adults and older people experiencing mental ill-health and treatment to adults and young people, in secure and specialised settings.
- Community services - community support and treatment for adults and children in community hospitals, health centres, GP surgeries and patients' homes.
- Learning disabilities services - community learning disability teams work in partnership with local councils to provide assessment and support for adults with learning disabilities. The Trust also provides specialist inpatient services.
- Social care - personalised social care support to people with a range of needs, including people with learning disabilities or mental ill-health, including support for people to live independently.

The Southampton adult mental health service has recently changed with the aim of making the care pathway simpler, safer and more responsive. In November 2015 the service produced a new patient information leaflet.
There are now three community mental health teams (CMHT) - east, central and west and one 24-hour acute mental health team. There are also the following teams:

- early intervention in psychosis team
- assertive outreach team
- custody liaison and diversion team
- psychiatric liaison team at Southampton general hospital
- rehabilitation services.

The Trust has been closely scrutinised by the Mazars review team and by the Care Quality Commission in recent months.