

**An independent
investigation into the care
and treatment of a mental
health service user (SN) in
Eastbourne by Sussex
Partnership NHS Foundation
Trust**

February 2015

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1. EXECUTIVE SUMMARY

- 1.1 NHS England, South Region commissioned Niche Patient Safety,(Niche) a consultancy company specialising in patient safety investigations and reviews, to carry out an independent investigation into the care and treatment of a mental health service-user (SN). The terms of reference are at Appendix 1.
- 1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, on the discharge of mentally disordered people, their continuing care in the community and the updated paragraphs 33-36 issued in June 2005.
- 1.3 The main purpose of an independent investigation is to identify whether there were any aspects of the care which could have altered or prevented the incident. The investigation process will also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning.
- 1.5 We would like to express our sincere condolences to Mr P's family.

The Incident

- 1.6 On 16 August 2012 SN was involved in a fight with in the Hydneye area of Eastbourne. Mr P was attacked by several youths and died in hospital on 17 August 2012 from his injuries.
- 1.7 SN had a long history of contact with child and adolescent mental health services (CAMHS). He had been diagnosed with of Attention Deficit Hyperactivity Disorder (ADHD) at the age of four or five years and had received treatment for this condition. He had a history of antisocial behaviour, school exclusion and offending.
- 1.8 SN spent six months in a youth offender institute (YOI) when he was 16, after he and another youth had assaulted and injured two men previously unknown to them. He had no contact with mental health services when he was released from the YOI, and care was provided by his GP between 2010 and 2012.
- 1.9 After a routine medication review by his GP in January 2012, SN was referred for a specialist review of his medication to the local primary care mental health service, Health in Mind (HiM). He was immediately referred to the community mental health team to see a psychiatrist for a medication review.

- 1.10 SN was seen twice by a trainee psychiatrist from the Adult Mental Health Team of Sussex Partnership NHS Foundation Trust (the Trust) in Eastbourne, and offered a referral to psychology and vocational services support with employment. In the review meeting with the trainee psychiatrist he said he was using between 2 and 8 grams of cannabis a week, had no plans to reduce this, and did not want to see staff from substance misuse services. SN did not attend for his third appointment with the psychiatrist, in June 2012, and did not respond to an 'opt in' letter asking him if he wished to have further involvement with the service. A vocational support worker telephoned him in July 2012 and was told by SN that he had moved to Manchester and did not need any more help from them.
- 1.11 SN had been living with a family friend when he was released from the YOI in February 2010, but by early 2012 was 'sofa surfing' with friends in the Hampden Park area of Eastbourne. In June 2012 he stopped renewing prescriptions from his GP for the medication (Quetiapine¹ 25 mg twice daily) recommended by the trainee psychiatrist.
- 1.12 On the evening of 16 August 2012 Mr P, a 46 year old man who lived nearby, had walked to the shop with his dogs.
- 1.13 Shortly before 21.00 Mr P became involved in an altercation with a group of teenage boys. One of them shouted up to SN who was smoking cannabis in the flat above. SN joined the scene which had now deteriorated into a physical fight. Mr P was punched and knocked unconscious. He never regained consciousness and died the following day. A post-mortem examination found that Mr P died as a result of injuries to his head.
- 1.14 SN was arrested on 20 August 2012 and charged with murder. He was assessed by a Criminal Justice Liaison Nurse at Eastbourne Magistrates Court on 20 August 2012, and was not considered to be in urgent need of assessment under the Mental Health Act. It was suggested he should be referred to mental health services if he was remanded in custody. He was remanded to HMP Lewes until the trial in February 2013.
- 1.15 On 6 February 2013 at Lewes Crown Court he was found guilty of murder, along with a 15 year old boy. On 15 March 2013 he was sentenced to life imprisonment, to serve a minimum of 11 years.
- 1.16 Following this tragic incident Sussex Partnership NHS Foundation Trust (the Trust) conducted an internal investigation which identified three Care Delivery Problems (CDPs) and a number of contributory factors.

The CDPs were:

¹ Quetiapine is used to relieve the symptoms of schizophrenia, bipolar disorder, and other similar mental health problems
<http://www.patient.co.uk/medicine/quetiapine>

1. Lack of communication with the team and the patient regarding the outcome of the psychology assessment. No recording of decision making was made by the psychology team, and no attempt was made to communicate to SN with the outcome of the decision not to offer him psychological therapy.
2. No referral to substance misuse services was made, although SN had previously been reluctant to be referred to the service.
3. Potential gap in provision following release from HMYOI Cookham Wood. A discharge letter was sent to his GP by the YOI, with a comprehensive assessment of needs, and reporting that SN was willing to work with his GP, but did not wish to link with Community Mental Health Services.

The contributory factors identified were:

Patient factors:

- SN lifestyle and lack of support networks.
- SN misused cannabis and was known to have a history of risk taking.

Task Factors:

- Reports from the mental health team in Eastbourne are unclear in relation to communication of decisions about psychology input to the patient.
- Psychology did not see SN face to face after referral was made. (Psychology Team would not necessarily need to assess every referral made face to face). Their view was that psychological therapy intervention would not be likely to succeed unless SN was actively engaged with SMS services to reduce substance consumption. This decision was not communicated with SN or his GP.

Communication Factors:

- Communication about the psychology decision to not accept for assessment appears to be inadequate. Discussed in psychology Team Meeting, with only outcome of discussion briefly recorded.
- Although advice was given to SN regarding reducing cannabis use there is no evidence of referral or liaison with substance misuse services.

Team Factors:

- Clarity of who should inform the patient about the decision about psychology is unclear.

- 1.17 The Trust's investigation also developed a number of lessons to be learnt and recommendations. The recommendations of the internal investigation are in section 6 of this report and the Trust's action plan is at appendix 3.
- 1.18 The independent investigation team has studied GP notes, medical, youth offending team and prison records, and policies. We have also interviewed those most closely involved in SN's care and had meetings with SNs mother

and SN. The family of Mr P was invited to participate in the independent investigation but did not wish to.

1.19 We endorse the Trust's identification of Care Delivery Problems and their contributory factors and with the recommendations and lessons to be learnt.

1.20 In addition, our independent investigation has developed further findings in the following areas:

- Communication with families after a serious incident
- Management of difficult to engage service users
- Communication between GP, mental health services and youth offending teams
- Transition between young offenders institutions (YOI) and mental healthcare for young people

1.21 In the light of our findings we believe that it was predictable that SN would be likely to come to police attention because of an act of aggression or drug related issue at some point after his period of release on licence ended in 2010. However the timing, nature and severity of any violence were not predictable. It is notable that by the time of the homicide in 2012, he had not further come to the attention of police for an act of violence since 2009.

1.22 It is our opinion therefore that this tragic event was neither predictable (in the nature and seriousness of the event) nor preventable by mental health services.

1.23 However, the independent investigation team believes there are lessons to be learnt and has made the following recommendations:

Recommendation 1. Commissioners should consider developing pathways of care that identify young people at risk of mental health problems in custody, and co-ordinates their care across primary and secondary mental healthcare, and youth justice teams.

Recommendation 2. The Trust should ensure that serious incident investigations are of the requisite quality standard and are sufficiently rigorous and robust to enable proper organisational learning.

Recommendation 3. The Trust should ensure that staff undertaking serious incident investigations are suitably trained, prepared and supported.

Recommendation 4. The Trust should ensure that the clinical risk assessment and management and active engagement policies are consistently implemented.

Recommendation 5. The final outcome of contact with secondary mental health services should always be communicated to the service users' GP. The CCG and Trust should agree the routes of

communication between secondary mental health services and GPs, and embed these into practice.

Recommendation 6. Following a serious incident such as a homicide, the Trust should incorporate best practice guidance available, including the Memorandum of Understanding² that exists between the Department of Health, the Association of Chief Police officers and the Health and Safety Executive. This would ensure that timely contacting with victim and perpetrator's families to agree how they would like to be engaged would be established in practice and policy. The resources of Police liaison and homicide teams, victim support or other available advocacy or support services should be used to support the process.

1.24 The following examples of good practice have been highlighted:

1. The CAMHS In-reach service in HMP YOI Cookham Wood went to great lengths to establish contact with SN's GP and with the Youth Offending Team (YOT), despite the geographical distance;
2. The YOT service provided a comprehensive structured service to SN on release from custody;
3. The outcome of the out patients appointment was faxed to the GP on the same day, with a request to prescribe medication.

² Memorandum of understanding between the NHS counter fraud service and the Association of Chief Police officers http://www.nhsbsa.nhs.uk/Documents/mou_acpo_cfs.pdf

2. INTRODUCTION

- 2.1 On 16 August 2012 SN was involved in a fight with other youths in the Hydneye area of Eastbourne. Mr P was attacked by several youths, and died in hospital on 17 August 2012 from his injuries.
- 2.2 SN was homeless at the time, and was staying in a friend's flat above a shop in the Hydneye. SN had a long history of contact with child and adolescent mental health services. He had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) since the age of four or five, and had received treatment and medication for this condition. He had a history of antisocial behaviour, school and exclusion.
- 2.3 SN had a brief period in the care of the Trust between January and June 2012.
- 2.4 The investigating team would like express our sincere condolences to Mr P's family.
- 2.5 We would like to express our thanks to the families, and members of staff of the Trust, YOT and GP practice involved for their contributions.

DETAILS OF THE INVESTIGATION

3. APPROACH AND STRUCTURE

Approach to the investigation

- 3.1 The independent investigation follows the Department of Health guidance (94) 27³, guidance on the discharge of mentally disordered people and their continuing care in the community, and updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in Appendix 1.
- 3.2 The main purpose of an independent investigation is to discover whether there were any aspects of the care which could have altered or prevented the incident. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 3.3 The overall aim is to identify common risks and opportunities to improve patient safety, and make recommendations about organisational and system learning.

³ 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*

- 3.4 The investigation was carried out by Carol Rooney, Senior Investigation manager for Niche, with expert advice provided by Dr Mark Potter. The investigation team will be referred to in the first person plural in the report.
- 3.5 The report was peer reviewed by Nick Moor, Niche Director. The profiles of the team can be found at Appendix 6.
- 3.6 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance⁴.
- 3.7 We used information from SN's clinical records and evidence gathered from the internal investigation report. As part of our investigation we interviewed:
- the author of the internal investigation;
 - the psychiatrist who saw SN twice as an outpatient;
 - the Service Manager of Eastbourne adult mental health service;
 - the psychologist who was consulted about referral of SN
 - The consultant psychiatrist from the YOI and
 - SN's GP.
- 3.8 These interviews were recorded and transcribed. The transcripts were returned to the interviewees for corrections and signature. A telephone interview was conducted with the supervising consultant psychiatrist at the Trust.
- 3.9 We had access to the Trust's papers produced at the time of the internal investigation. We met the lead author of the internal investigation in order to understand the Trust's investigation process.
- 3.10 We wrote to SN at the start of the investigation, explained the purpose of the investigation and asked to meet him. We then met him at HMYOI Feltham. SN gave written consent for us to access his medical and other records. We gave SN the opportunity to comment on a draft before it was finalised.
- 3.11 We met SN's mother and explained the purpose and process of our investigation. We also invited her to share her views on the care and treatment provided to her son.
- 3.12 We wrote to SN's father to invite him to participate in the investigation but, he did not respond.
- 3.13 We spoke to the victim's brother, by telephone, who did not wish the family to contribute to the investigation into mental health services.

⁴ National Patient Safety Agency (2008) *Independent Investigations of Serious Patient Safety Incidents in Mental Health Services*

3.14 We met with SN's individual and substance misuse workers at the Eastbourne YOT.

3.15 A full list of all documents we referenced is at Appendix 4.

Structure of this report

3.16 Section 4 sets out the details of the care and treatment of SN. We have included a full chronology of his care at Appendix 2 in order to provide the context in which he was known to Trust services.

3.17 Section 5 examines the arising issues from SN's care and treatment, and includes comment and analysis

3.18 Section 6 reviews the trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

3.19 Section 7 sets out our overall analysis and recommendations.

4 THE CARE AND TREATMENT OF SN

Childhood and family background

4.1 SN was born in 1993 in Lancashire, where his parents lived. His mother moved to the South Coast when SN was about six.

4.2 SN's mother re-married in Eastbourne when SN was about eight years old. SN has two younger half-sisters.

4.3 SN was diagnosed with ADHD when he was around four or five years old and was treated with Atomoxetine⁵ and Methylphenidate⁶ medication.

4.4 As part of his ADHD presentation SN showed significant challenging behaviour. He was described by the school and his parents as aggressive, impulsive, and swearing at adults and children.

⁵ Atomoxetine (STRATTERA®) is approved for the treatment of attention-deficit/hyperactivity disorder (ADHD) in children aged 6 and older, teens, and adults. Strattera should be used as part of a total treatment program for ADHD that may include counseling or other therapies

⁶ Methylphenidate (CONCERTA®) is a prescription product approved for the treatment of attention deficit hyperactivity disorder (ADHD) as part of a total treatment program that may include counseling or other therapies

- 4.5 There were frequent school exclusions for violence, bullying of other children and swearing. It was reported that SN continued to behave badly at home as well as school. His mother described him lying, swearing at her, stealing and breaking household items.
- 4.6 In 2006, at age 13, he went to live with his father in Blackpool.
- 4.7 On a visit to Eastbourne in 2008, when SN was 15, he ran away and refused to return to Blackpool. He did not return to the family home but his mother paid for him to stay in rented accommodation in Eastbourne. Children's Services set up a foster care placement but this did not work out, and he also lived with his maternal grandmother for a time.
- 4.8 SN was accommodated in a hostel which was part-funded by Social Services, but would not stay because of drugs and violence in the hostel, and because he felt isolated from his friends. The YOT had arranged for him to have an accommodation interview with the YMCA, with funding support from the 'sixteen plus' service.
- 4.9 Prior to the offence he was living on friends' sofas in the Hampden Park area of Eastbourne.

Education and Employment History

- 4.10 SN attended school in Eastbourne. His schooling was frequently interrupted by exclusions and he was excluded in year 9 for defiance in class and fighting with other boys. He was again excluded in Year 10 for aggressive behaviour. In May 2006 aged 13, he was on a reduced timetable of 2 hours a day due to his behaviour. His mother requested he be admitted to Cuckmere School for pupils with special education needs.
- 4.11 He frequently truanted, and left school with two GCSEs. He was turned down for a carpentry course at Sussex Downs College because of concerns about his previous record of attendance and behaviour but was placed on an alternative course which he fully participated in.
- 4.12 SN has not been employed.

Relationship history

- 4.13 Aged 17 SN had a girlfriend for about 18 months and his mother told us she thought this '*was a good thing for him*'. It was reported by the YOT team that one of his girlfriends was known to the YOT and would encourage him to use violence.

Substance misuse, criminal justice and psychiatric history:

Substance misuse history

- 4.14 SN began using alcohol from the age of 10 years and according to CAMHS notes was drinking regularly throughout his teens. By age 15 he was drinking about 8-12 units 2 or 3 times a week, but without signs of physical dependence. He was reported as being able to recognise that drinking to excess leads to him getting into trouble, particularly with regard to getting into fights. He used to play a lot of football and was an active member of schoolboy teams.
- 4.15 SN used cannabis daily from the age of 13, smoking with groups of friends, he has denied using any other drugs. SN was assessed by the 'Under 19' Substance Misuse Service who reported that he was difficult to work with as he was not willing to reduce alcohol consumption or give up cannabis at the time. Both substances appeared to be an integral part of his peer group at the time.
- 4.16 SN has reported using cannabis to self-medicate his ADHD, and did not take his prescribed medication regularly because of the side effects – reporting that it made him feel like a 'zombie.'

Contact with criminal justice system

- 4.17 SN had five convictions relating to 10 offences by 2009. He was released on a six month licence⁷ in March 2010, when he was 17, with close supervision from the YOT. He was subject to an electronic curfew for the first month and it had been arranged that he would live with a family friend in Eastbourne. He was seen for regular supervision by his YOT worker.
- 4.18 In June 2009, aged 16, SN was found guilty of burglary of a dwelling, and in August 2009 found guilty of assault by beating, threatening abusive or insulting behaviour, and criminal damage. He received a supervision order that extended his previous one to 24 months.
- 4.19 In September 2009, aged 16, SN was found guilty of assault by beating and actual bodily harm, in an incident which took place on the seafront in July 2009.
- 4.20 Although in the pre-sentence report his YOT's worker recommended a Supervision Order, he received a 12 month Detention and Training Order on 23 September 2009 and was sent to HMYOI Cookham Wood.
- 4.21 During the six month licence period SN was provided with a comprehensive support package which included problem solving and anger management, education and training support, and substance misuse work. His motivation to find work was reported to be lacking by the education support worker, but

⁷ Under the new sentencing provisions of the Criminal Justice Act 2003, young people serving a sentence of 12 months and over can be released on licence and subject to YOT supervision throughout the whole of the second half of their sentence.
<http://www.yjbstandards.org/national/resources/documents/Ref%2040%20release%20and%20recall%20guidance.pdf>

he engaged well initially with the substance abuse worker, reducing his use of cannabis and alcohol.

Psychiatric history - CAMHS

- 4.22 SN had a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) from and was treated by the CAMHS service from the age of four.
- 4.23 SN was reviewed regularly by CAMHS psychiatrists, and had monthly clinic appointments with the nurse consultant for ADHD in the CAMHS behaviour support and medication monitoring service. This service regularly updated the school on SN's progress, and provided monitoring forms to be completed for progress reporting. He was described as aggressive, impulsive, and swearing at adults.
- 4.24 Contact with CAMHS continued throughout 2005 and 2006, and there were frequent school exclusions. SN's behaviour was problematic at home as well as school. He began to refuse to attend CAMHS appointments and in 2006 went to live with his father in Blackpool. SN told us he was given ADHD medication in Blackpool by a GP.
- 4.25 Although he returned to live in Eastbourne in 2008, his last contact with CAMHS was in 2009. SN describes his experience of CAMHS as focussed on medication only, and said he would have liked more help with behaviour and problem solving.
- 4.26 His GP prescription of Atomoxetine⁸ finished in June 2006, and no further ADHD medication was prescribed by his GP until March 2010
- 4.27 SN was referred to the Mental Health In reach Team at Cookham Wood in 2009 due to his impulsive aggressive behaviour and inability to cope with the structures and demands placed on him in the prison education system. At assessment by the consultant adolescent psychiatrist he was restless, hyperactive and easily distracted, with no thoughts of self-harm. He asked for help with his anger and agreed to start on medication, and engage in anger management. He responded well to the medication and his behaviour improved.
- 4.28 However he developed resting tachycardia,⁹ and was referred to hospital for investigations to be carried out; meanwhile the Atomoxetine was stopped as

⁸ Atomoxetine is used to treat attention deficit hyperactivity disorder (ADHD). <http://www.patient.co.uk/medicine/atomoxetine-for-adhd-strattera>

⁹ Tachycardia is a heart rate that exceeds the normal range. In general, a resting heart rate over 100 beats per minute is accepted as tachycardia. Tachycardia can be caused by various factors that often are benign. However, tachycardia can be dangerous, depending on the speed and type of rhythm. <http://en.wikipedia.org/wiki/Tachycardia>

it was thought it may be the cause. Nothing significant was found at investigation at Eastbourne Hospital.

- 4.29 At Cookham Wood he was diagnosed as having ADHD, and chronic trauma symptoms such as difficulty in falling asleep, arousal symptoms, and flashbacks of upsetting childhood experiences. These were treated with Mirtazapine¹⁰ and responded well. As his levels of arousal decreased, this was changed to a small dose of Risperidone¹¹ (0.5mg) that could be used in the short term to treat adolescent conduct disorder. He also had psychological input based on Cognitive Behavioural Therapy (CBT). A week before his early release on licence he was prescribed Methylphenidate 36 mg (Concerta XL) and Risperidone 0.5mg.
- 4.30 At the time of his release a comprehensive discharge summary with recommendations was sent to his GP and to the YOT team. SN refused a referral back to CAMHS as he said he did not have a good experience with the service. Links with YOT had been made before his release, and there was a formal monitoring and support structure in place because he had been released on licence. SN complied with this mandatory monitoring structure.

Psychiatric history - Adult Mental Health Services

- 4.31 SN saw his GP only once, for vomiting symptoms, between March 2010 and January 2012.
- 4.32 In January 2012 a medication review was triggered by the GP's system, and the GP noted that there had been no recent specialist review of his ADHD medication. The GP referred SN to the Primary healthcare mental health team 'Health in Mind' for a psychiatric medication review. This was SN's first contact with adult mental health services.
- 4.33 Primary care mental health services are provided by 'Health in Mind' (HiM) which is a service designed to bridge the gap between GP care and mental health services. This has been achieved by placing a mental health professional in each GP surgery. They advise on the most appropriate treatment and can facilitate access into which ever service is appropriate. The East Sussex HiM is not funded by commissioners to employ a psychiatrist, therefore cannot carry out specialist reviews of medication.
- 4.34 Any request for a review of psychiatric medication triggers a referral by the HiM worker to a secondary mental health service's psychiatrist, purely for the

¹⁰ Mirtazepine is a medicine used to treat depression.

<http://www.medicines.org.uk/emc/medicine/24376/SPC/Mirtazapine+30mg+Tablets/>

¹¹ Risperidone is an antipsychotic drug that can be used in smaller doses as short-term treatment (up to 6 weeks) of long-term, aggression in children and adolescents with conduct disorder. <http://www.drugs.com/uk/risperidone-0-5-mg-film-coated-tablets-leaflet.html>

medication review. The person is not regarded as being formally referred to secondary mental health services. In SN's case the referral to HiM was completed by the GP where it was assessed that there were no risk indicators for suicide, self-harm or harm to others noted. The referral was prioritised by a mental health nurse, and then forwarded on for a psychiatric assessment/review only, with 'no further HiM intervention required'.

- 4.35 SN was reviewed by CT1 N (trainee psychiatrist) on 17 February 2012, approximately 3 weeks after referral, in the company of his mother. Both his mother and the professionals involved told us they thought it was unlikely he would have attended if he was on his own. At the outpatient appointment the trainee psychiatrist thought his ADHD symptoms were very evident, but SN indicated he would not take medication for ADHD, and admitted he was using cannabis heavily to control symptoms of ADHD. It was agreed with the supervising consultant that Quetiapine¹² may be helpful in calming his symptoms, and may be more acceptable to him because of less likely side effects. A referral to psychology was offered following consultation with the supervising psychiatrist, because there appeared to be issues that may be appropriate for psychological intervention. The diagnosis given was ADHD, Unsocialised Conduct Disorder, Mental and Behavioural Disorder due to use of cannabinoids.
- 4.36 SN was strongly advised to reduce his use of cannabis and was offered a referral to substance misuse services. In the review meeting with the trainee psychiatrist he said he was using between 2 and 8 grams of cannabis a week, and had no plans to reduce this. He was offered a referral to substance misuse services but it was reported that he refused to engage with them. There were no problems reported with mood, but it was noted that he was unable to maintain eye contact and was reported to be restless and fidgety. He was assessed as at low risk of self-harm, neglect and violence. HONOS¹³ score was 19, and PBR¹⁴ cluster 4 which means non-psychotic (severe). This group is characterised by severe depression and/or anxiety and/or other increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

¹² Quetiapine is an antipsychotic medicine. It works by changing the actions of chemicals in the brain, and may be used for other purposes.

¹³ HoNOS is the most widely used routine clinical outcome measure used by English mental health services and is an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning. HoNOS is a rating scale on which service users with severe mental illness are rated by clinical staff. The idea is that these ratings are stored, and then repeated- after a course of treatment or some other intervention- and then compared. If the ratings show a difference, then that might mean that the service user's health or social status has changed. They are therefore designed for repeated use, as their name implies, as clinical outcomes measures. HONOS is not a risk assessment, but relies on the completion of a clinical risk assessment (Wing, Curtis & Beevor, 1996). <https://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/courses/honos/whatishonos.aspx>

¹⁴ PbR is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs. <https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013-14>

A 5 point plan was agreed:

1. 7 day prescription of Quetiapine 25 mgs, with a request to his GP to continue
 2. Referred to vocational team to support looking for work
 3. Referred to psychology
 4. Advised to reduce use of cannabis
 5. See again in outpatients in a month
- 4.37 The summary letter was sent to the referring GP and copied to both the consultant psychologist in the secondary care team and to SN. A fax was sent to the GP by the trainee psychiatrist advising the GP of what medication he had prescribed (Quetiapine 25mg twice a day), and advising that Concerta had been stopped due to “non-compliance and side-effects”. The fax was signed as received by the GP and actioned.
- 4.38 Quetiapine was prescribed by the GP between 24 February 2012 and 22 June 2012. It is not known whether SN completed the prescriptions or took the medication regularly.
- 4.39 CT1N discussed SN with lead Psychologist 1 based in the secondary mental health team. On the basis of this discussion Psychologist 1 decided he was not suitable for psychological therapy, particularly because he would not engage with substance misuse services. This decision was recorded on a handwritten referral outcome note by Psychologist 1. CT1N believed the referral was still active, and was expecting the Psychologist to meet SN with him at the next Out Patient Appointment as had been agreed. He did not know why this had not occurred.
- 4.40 SN was seen at appointment by CT1N on 16 March 2012 as planned, again attending with his mother. He appeared to have responded well to the Quetiapine, he was calm and his sleep and energy levels had improved and he was able to engage with CT1N. SN completed the application forms to the vocational team, but continued to smoke cannabis and expressed no desire to reduce this. The Risk Assessment was revised to add that risk to others remained moderate because of his history of violence and continued unpredictability. The plan was revised to include:
1. No changes with medication as agreed with SN
 2. Still on the waiting list for psychology
 3. Vocational team to provide further input
 4. See again in 3 months or sooner if needed
- 4.41 The letter was sent to the GP and copied to SN, but not the lead psychologist.
- 4.42 SN did not attend for the third appointment, and was sent an ‘opt-in’ letter to his mother’s address (a letter asking him to make contact within 3 weeks if he wished to use the service). The secondary mental health team vocational

support worker phoned him on 4 July 2012 to follow up and was told he had relocated to Manchester.

- 4.43 This was the last contact before the incident in August 2012. It was reported at interview by the trainee psychiatrist that there was a discussion between himself and his supervisor about whether to follow up after SN did not attend. It was decided not to, based on their belief that SN did not really wish to engage, and had only attended because his mother brought him to the appointment.

5. ARISING ISSUES, COMMENT AND ANALYSIS

- 5.1 In this section we review the policies and procedures in place in the Trust when SN was known to the services. We also looked at the Trust's current policies and procedures and other documentation to establish what improvements have been made since the incident in August 2012. We interviewed senior Trust managers who gave us examples of how policies and procedures have been changed and implemented. A full list of the documents reviewed can be found in appendix 4.

- 5.2. We have focussed on the points identified in the terms of reference for our independent investigation and further areas that have emerged during our investigation. We have reviewed the documents that the Trust have provided as evidence of implementation.

The terms of reference for this investigation asked that we:

- 5.3 Review the care, treatment and services provided by the NHS, the prison service and other relevant agencies from SN's first contact with services to the time of his offence.
- 5.4 Review the appropriateness of the treatment of SN in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- 5.5 Review the adequacy of risk assessments and risk management, including specifically the risk of SN harming himself or others.
- 5.6 Review the effectiveness of SN's care plan including the involvement of the service user and the family.
- 5.7 Involve the families of both the victim and the perpetrator (in the independent investigation) as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations and incorporate family perspective into the terms of reference.

Comment

- 5.8 From our investigation we find that SN was provided with appropriate care and treatment for ADHD by the CAMHS service in Eastbourne, in line with NICE Guidelines¹⁵ and the (undated) Trust 'Guidelines for the Assessment and treatment of Children and Adolescents with Inattention, Impulsivity Hyperactivity and Associated Difficulties' which includes medication, individual and family support, and joint working with school and health services.
- 5.9 SN reported that he did not like taking the various medications prescribed as he experienced significant side effects. These were changed as required, with monitoring from CAMHS service until 2009.
- 5.10 It appears that the period of detention and input from the mental health in reach team in HMYOI Cookham Wood provided some much-needed stability and boundaries to SN's care. He did not have the problems of finding accommodation, and did not have access to cannabis, alcohol or the delinquent lifestyle he had been leading up to this point.
- 5.11 It is clear from assessment reports from November 2009 and our interview with the CAMHS in reach adolescent psychiatrist that the in reach team worked hard to engage SN and provide him with a treatment package that would meet his needs in custody.
- 5.12 The in reach team tried to support a transition of care to his home area by contacting the YOT worker who would be supervising his licence, and writing a discharge letter to his GP. The good practice in supporting the transition from custody to care is to be commended.
- 5.13 SN was 17 at the time of release and he had a significant mental health service history as a CAMHS patient. The arrangements for mental health assessments and in reach in prisons for adults are well developed, and the Trust provides a mental health service for prisoners in two local adult prisons.
- 5.14 There is no comparative in reach service for young people, but there is a psychologist based in the Eastbourne YOT team, funded by the Trust. This would be the first point of community contact for mental health concerns for young offenders with mental health problems who are supervised by YOT.
- 5.15 SN seems to have responded positively to the resettlement support provided by YOT through the six month licence programme, and it appears to have been a beneficial structure for him.
- 5.16 The reports by the YOT are comprehensive and detailed, and give clear descriptions of his level of engagement. He was not able to source

¹⁵NICE guidelines 72 Attention Deficit Hyperactivity Disorder <http://www.nice.org.uk/CG72>

employment, and his motivation to apply for jobs was described as low by the resettlement worker.

- 5.17 While this structure was positive for SN individually, there was no structure or system that allows for reporting from the YOT service to be shared with CAMHS or in this case with SN's GP. The GP was not in fact aware of the YOT service's input.
- 5.18 It is evident that while SN was initially referred purely for a review of ADHD medication, this did in fact result in his being taken on as an active case by the secondary mental health services.
- 5.19 At the initial appointment the trainee psychiatrist conducted a thorough Psychiatric assessment and conferred with his supervising consultant psychiatrist for advice in managing a case which presented particular challenges.
- 5.20 A positive plan was developed that was acceptable to SN and his mother and the trainee psychiatrist communicated effectively with the GP in informing him of the outcome of the appointment.
- 5.21 The issue was discussed appropriately with the lead for psychology.
- 5.22 The communication from psychology was acknowledged in the internal investigation as inadequate, and a review of psychology referral processes and communication of outcomes has been put in place since this incident as part of the action plan.
- 5.23 The Trust's Clinical Risk Assessment and Management (CRAM) policy and procedure dated 24 January 2012, states that *'all service users will at the point of first contact or assessment minimally will have a screening risk assessment using the documentation specific to the care group and service area in which they present'*.
- 5.24 The standard referral form for HiM was completed by the GP, which included a section with 'yes/no' answers to Risk Indicators for suicide, self-harm, harm to others and self-neglect. The GP indicated that none of these risks were present, but did not indicate whether it was a 'priority referral' or not. The GP did however include the YOI's assessments and correspondence with the referral. The clinical notes record that these were received, and there was a note on file to request that CAMHS notes are accessed, noting SN had an extensive CAMHS history. There is however no record of whether these were accessed or not.

- 5.25 The consultant adolescent psychiatrist from the YOI clearly indicates in his discharge letter that in 2010¹⁶ SN was *'at risk of engaging in impulsive, aggressive behaviour, and the risk will be further increased if he misuses drugs or alcohol. Compliance with the medication for ADHD may offer some protection against impulsive aggressive behaviour by providing him with a window of opportunity to reflect on the consequences of his behaviour and choose prosocial behaviour. He is at higher risk of developing substance dependence, and would benefit from input from the substance misuse team as well as CAMHS. He has not engaged in any self-harming behaviour during his stay. He is not at risk of abuse from others, though is vulnerable to exploitation'*.
- 5.26 The 'initial intervention' form completed by the HiM's mental health nurse indicated that SN required a psychiatric assessment/review and one was faxed to the secondary mental health service with the referral form. It was noted that there is no area on this form for risk information.
- 5.27 According to the CRAM policy an 'Access Risk Screening Tool' should have been completed at SN's first meeting. All HiM's first contacts should have the HiM's 'Initial assessment form' and HiM's risk screening tool' completed. All of these forms include assessments of risk of suicide, self-harm, self-neglect, harm to others and risk to children.
- 5.28 The HiM's Risk Screening Summary requires the assessor to indicate whether they believe that this person could cause harm to others, and if this is true, a full CPA Level 1 Risk assessment should be completed.
- 5.29 The Level 1 risk assessment has a section on 'Aggression and Violence' which if completed could have shown that SN had a significant history of violence, dangerous impulsive acts, substance misuse, previous admission to a secure facility and signs of anger and frustration. With hindsight we believe this should have contributed to a different level of risk assessment.
- 5.30 The outpatient appointment letter, written by CT1N in February 2012, refers to SN's YOI history, but not his CAMHS history. The risk assessment was noted as low for self-harm, self-neglect and violence.
- 5.31 The HONOS' rating was completed by the supervising consultant psychiatrist on 17 February 2012, and it scored three for current overactive, disruptive or agitated behaviour, and historical agitated behaviour is scored four. The total HONOS score was identified as 19, and the PbR cluster was rated at four, suggesting a non-psychotic disorder.
- 5.32 At the second appointment undertaken in March 2012, risk assessment for 'risk to others' was changed to moderate *'as he has a history of violence and remains unpredictable'*. It was noted that SN presented as *'calm, able to*

¹⁶ Discharge letter from Cookham Wood CAMHS in reach psychiatrist dated 10 March 2010

maintain eye contact, with much slower and coherent speech than previously'. The changes to risk assessment were explained at interview with investigators as related to his not taking medication regularly.

- 5.33 At this appointment the PbR cluster was revised to zero which indicates a variance – the zero category is a summary cluster that refers to a group of patients that are not adequately described by any of the other cluster descriptions, despite careful consideration of all the other Mental Health Care Clusters.
- 5.34 SN was invited, by letter to his mother's address, to a follow up appointment, arranged for 15 June 2012. This letter was also copied to the GP, however the lack of any subsequent contact was not conveyed to the GP.
- 5.35 SN did not respond, and no further action was taken. The Trust's 'Active Engagement Incorporating Did Not Attend (DNA) Management policy and procedure, dated May 2012, states where the service user is already engaged with or known to the service:

'The Practitioner/Care Coordinator should contact the service user directly to identify the reason for the DNA/cancellation and arrange another appointment using the preferred method of the service user. The GP and/or referrer should be contacted if appropriate. Where no contact can be made, or for a second consecutive DNA, the practitioner should review the service user's care within a multidisciplinary team forum, involving other agencies or individuals involved in their care as is clinically appropriate. Depending on the outcome of the multidisciplinary assessment of potential risk, the next course of action can be determined. This could be another appointment, a care co-ordination meeting, a home visit or discharge back to primary care following liaison with the GP and/or referrer as appropriate'.

- 5.36 Both psychiatrists at interview expressed the view that SN had attended initially reluctantly, and that his mother had made sure he attended the appointments.
- 5.37 SN was assessed as having capacity, although there is no formal assessment recorded.
- 5.38 It is not clear whether the information about SN moving to Manchester was communicated to CT1N by the vocational worker. SN confirmed to us at interview that he had moved to Manchester for a short period around this time with the intention of making a fresh start, but returned to Eastbourne some time later when things did not work out.
- 5.39 The Trust's Clinical Risk Assessment and Management policy gives clear and comprehensive guidance and structure for the completion of risk assessments.

- 5.40 The structures of this policy were not followed, and at interview it was clear that CT1N had not accessed the previous CAMHS's records in order to review SN's history.
- 5.41 An assessment of clinical risk was made and described at both appointment meetings in February and March 2012, but there is no evidence that the approved structured assessment tools were used.
- 5.42 Consequently it is difficult for the investigators to ascertain why the risk assessment for violence was changed from low to moderate, in the absence of the structured tool. We do, however, concur that his risk of violence was moderate, based on his past history.
- 5.43 SN's risk of harm to himself was assessed as low and we concur with this assessment based on the history but again there is no record of an objective clinical risk assessment being undertaken.
- 5.44 The Trust's Active Engagement policy, which incorporates a Did Not Attend (DNA) Management protocol was not followed after SN's non-attendance in June 2012.
- 5.45. There was no direct contact other than a letter attempted and there was no feedback on the outcome of this process to the GP. The use of mobile telephone contact or social media networks could have been helpful.
- 5.46 At interview we were told by the service manager of the secondary mental health service that this policy was '*not rigorously followed*' at that time.
- 5.47 There is no record or recollection of a multidisciplinary discussion about risk, though the secondary care medical team reported discussing his case in supervision and had not regarded him to be of such significant risk of violence that further action was required.
- 5.48 The GP was not provided with any information about the final outcome of the contact with secondary mental health services.

Involvement of families in the independent investigation

P family:

- 5.49 Through the Sussex Police's Family Liaison Office Mr P's brother was identified as speaking for the family. He was contacted by phone by the investigation team to ask if the family would like to contribute to the investigation and terms of reference. He expressed the view that because the investigation was about mental health services, rather than any issues directly relevant to his brother's death, the family did not wish to take part.
- 5.50 He was also concerned that it was over two years ago and he did not want the family to have to 'rake over' it all again. He stated he would be open to

an approach when the investigation had concluded, and would decide then if the family would take part.

SN's family:

- 5.51 SN's mother was seen by the lead investigator, accompanied by the GP and was provided with a summary of the meeting, on which she gave comment. Her concerns were for any learning to be gained which may prevent any family from having a similar experience. Her main concerns were regarding the provision of suitable accommodation to support SN in having a better lifestyle. She had the opportunity to comment on the final report.
- 5.52 SN's father did not respond to our approach by letter to become involved.

SN:

- 5.53 SN agreed to meet with us in HMYOI Feltham, and he reported that it was his hope that something can be learned that may prevent a similar tragedy. He was clear that he had not sought the help of secondary mental health services, but was interested in help for anger management. However he said he found Dr N's plan helpful, but he had not taken the prescribed medication. He had in fact moved to Manchester temporarily when the vocational worker called him, and did not seek any further help when he moved back. He would have liked more support with anger management from the CAMHS service in the past, though agreed that it had been available at YOT.
- 5.54 SN pleaded not guilty to the murder and later appealed his sentence, though his appeal was dismissed. He said that at the time he had been protecting his friends and that he had no intention to do harm, and that he had not kicked Mr P. This investigation team cannot comment on this, but did conclude that in their opinion SN's mental health or ADHD do not appear to have had an influence on the offence. SN also stated he had never experienced any 'blackouts' but had told his mother that he had.
- 5.55 SN showed the investigation team a psychiatric report that had been requested by his solicitor and it was noted that it did not make any causal link between his offending and any mental disorder.

6 THE INTERNAL REVIEW

We have detailed the review of the internal investigation under the headings of the Terms of Reference.

Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.

- 6.1 The independent investigation has reviewed the internal investigation report guided by the NPSA investigation evaluation checklist.¹⁷ The internal investigation is described as a Level 2 comprehensive single incident review (Root Cause Analysis), and was carried out by a Service Director from another part of the Trust.

The Care and Service Delivery Problems identified were:

1. Lack of communication with the team and the patient regarding the outcome of the psychology assessment. No recording of decision making was made by the psychology team, and no attempt was made to communicate to SN with the outcome of the decision not to offer him psychological therapy.
2. No referral to substance misuse services was made, although SN had previously been reluctant to be referred to the service.
3. Potential gap in provision following release from HMYOI Cookham Wood. A discharge letter was sent to his GP by the YOI, with a comprehensive assessment of needs, and reporting that SN was willing to work with his GP, but did not wish to link with Community Mental Health Services.

The recommendations made were:

1. Review system for communication to all parties regarding psychology input with individuals. C&S Delivery problems 1 and Contributory Factors.
 2. Psychology to provide clear rationale for decisions which should be recorded in psychology team meeting referral and case discussion log book and eCPA and discussed with patient. C&S Delivery problems 1 and Contributory Factors.
 3. Psychology to assess all referrals face to face. Contributory Factors.
 4. Teams should liaise with substance misuse services more closely. C& S Delivery problems 2 Contributory Factors.
- 6.2 Although we concur with these recommendations, and have not repeated them, in our opinion the care and service delivery problems identified focused on record-keeping and documentation and did not sufficiently reflect the practice issues or wider service issues.
- 6.3 Our independent investigation has developed further findings in the following areas:
- Management of difficult to engage patients
 - Communication between GP, secondary mental health services and youth offending team

¹⁷ National Patient Safety Agency. *RCA Investigation Evaluation Checklist*.

- Transition between young offenders institutions (YOI) and mental healthcare for young people
 - Communication with family after serious incidents
- 6.4 We interviewed the author of the report and found that the investigation had not followed due process, and their evidence gathering had been not been thorough and comprehensive.
- 6.5 There are omissions in the description of SN's history of treatment for ADHD.
- 6.6 There is no mention of his significant history of CAMHS involvement by the Trust, or of the detail of his involvement with mental health in reach in HMYOI Cookham Wood, or of the support package provided by the YOT.
- 6.7 There are inaccuracies in the chronology :
- the date of SN's diagnosis with ADHD was given as 2009; when in fact he was diagnosed aged four or five in about 1997
 - the date of the incident was given as 17 June 2012; it was in fact 17 August 2012
- 6.8 The author stated that they had not had any training or experience in carrying out a serious incident investigation.
- 6.9 The type of review was described as a standard Root Cause Analysis¹⁸ (RCA) review with tabular timeline, using a statement from the psychologist and a letter from the GP. At interview the author stated the Consultant Psychiatrist, GP and Service Manager were all in fact interviewed but the transcripts were not available.
- 6.10 Neither the family members nor SN were interviewed as part of the internal investigation. The author could not clearly recall the reason for this decision, but with hindsight he suggested that that it must have been because of the on-going police investigation.
- 6.11 The report containing inaccuracies appears to have been accepted by the Director of Governance and the Chief Operating Officer in January 2013.
- 6.12 The report notes a potential service gap following his discharge from HMYOI, but does not address this in the recommendations or action plan.
- 6.13 We concur with the recommendation about communication between professionals and with the patient about the outcome of assessments.

¹⁸ Root Cause Analysis investigation is a well-recognised way of investigating safety incidents. Investigations identify how and why patient safety incidents happen. Analysis is used to identify areas for change and to develop recommendations which deliver safer care for our patients. <http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/>

However the detail of how this occurred was not explained in the internal report.

- 6.14 At interview CT1N stated he never knew why the psychologist did not attend the appointment, and continued to regard SN as being on the psychology waiting list. The report author stated he had not 'got to the bottom of it.'
- 6.15 It had been agreed that rather than do a separate assessment, the psychologist would sit in with the psychiatrist's next appointment with SN.
- 6.16 At interview the psychologist stated that this did not in fact occur because the appointment was on a Friday, when neither of the available psychologists worked.
- 6.17 We found that there had, in fact, been a decision made that SN was not suitable for psychological therapy because he was not willing to engage in substance misuse support, which was recorded by psychology on their referral form, but not communicated to either the psychiatrist or the patient.
- 6.18 The assessment by the psychologist was completed, on paper, following a discussion and not communicated formally as already highlighted. The assessment was requested because CT1N thought there may be psychological issues that SN could be helped with.
- 6.19 The psychologist's opinion was essentially that SN would need to engage with reducing substance misuse before psychological work could be offered, which we believe was reasonable.
- 6.20 This opinion was, however based on a conversation with CT1N, not on an assessment, and was not communicated to either CT1N or to SN.
- 6.21 The care plan developed for SN by CT1N is described in section 4.
- 6.22 SN was offered assistance with looking for employment through the vocational support worker, which was evidence of recognition that support to develop a pro-social lifestyle was considered and acted upon.
- 6.23 This was followed up by the vocational worker after the DNA for his last appointment and only ceased when SN reported that he had moved to Manchester.
- 6.24 The Quetiapine medication prescribed appears to have had some calming effect on SN, although it is not known how concordant he was with regular medication.
- 6.25 SN was assessed as having capacity to make decisions about his care plan, and appeared to have concurred with the plans made. He had not sought help from secondary mental health services himself but went along with his GP's referral to review his medication.

- 6.26 SN's mother was instrumental in bringing SN to both appointments, and it is the opinion of the professionals concerned that he would have been unlikely to attend if not brought by his mother. CT1 N reported that he appeared reluctant to engage, and had clearly been persuaded to attend by his mother. His mother confirmed this when we met her.
- 6.27 SN himself on reflection reported that says he would have liked some help with anger management and was not at all keen on taking medication or reducing his cannabis use.
- 6.28 From SN's history we believe it is clear that the most stable periods of his ADHD-related behaviour have been when he has been either incarcerated or otherwise legally compelled to co-operate with structures, boundaries and take regular medication in a supervised setting.
- 6.29 SN told us at interview that he has benefited from anger management whilst currently detained, and would have liked that to have been available to him in the community. He is clear that he did not like taking ADHD medication, because of the side effects and lack of benefit he experienced, and would not do so in future. He reported that he is not now taking medication for ADHD.
- 6.30 SN's mother was very motivated to try and get some help for her son, and was very concerned that he appeared to be living a pro-criminal lifestyle that left him vulnerable to the influence of others. In taking him to the appointment meetings she had hoped he could be prescribed some medication that would help him, and services that would help him control his anger.
- 6.31 Communication between SN's mother and the GP has been well established over many years, and this appears to have been a positive resource for her.
- 6.32 We consider that the care plan was developed with due care and attention to SN's needs, and with a positive and optimistic approach. SN himself had capacity and was not motivated to engage directly with a secondary mental health service.
- 6.33 There is no documented assessment of whether a Mental Health Act assessment was required or considered. While it is our opinion that there were no indicators in the history or presentation that he required a formal assessment at any point, it would have been helpful if the risk assessment had included a reference to this, as it did to capacity.
- 6.34 Although his care plans came to an end when he did not attend, and were somewhat 'left in the air', we do not believe that any act or omission on the part of Trust staff had any influence on subsequent events.

Recommendations

Recommendation 1. Commissioners should consider developing pathways of care that identify young people at risk of mental health problems in custody, and co-ordinates their care across primary and secondary mental healthcare, and youth justice teams.

Recommendation 2. The Trust should ensure that serious incident investigations are of the requisite quality standard and are sufficiently rigorous and robust to enable proper organisational learning.

Recommendation 3. The Trust should ensure that staff undertaking serious incident investigations are suitably trained, prepared and supported.

Recommendation 4. The Trust should ensure that the clinical risk assessment and management and active engagement policies are consistently implemented.

Recommendation 5. The final outcome of contact with secondary mental health services should always be communicated to the service users' GP. The CCG and Trust should agree the routes of communication between secondary mental health services and GPs, and embed these into practice.

Review the progress that the Trust has made in implementing the Internal Report's Action Plan:

- 6.35 We have seen an updated Action Plan from the internal Report that was signed as completed in January 2013 (Appendix 3).
- 6.36 We asked the Trust for evidence of any audits that may have taken place or service/policy changes that can give evidence of action plan implementation and/or embedded lessons learnt.
- 6.37 We did not conduct an independent audit of the evidence but relied on the Trust's feedback and scrutiny of the documentation supplied.
- 6.38 We were provided with agenda and minutes of Local Governance meetings referring to Serious Incidents, Substance Misuse Service and reviews of lessons learnt (discussed monthly at East Sussex Adult Services Governance Meeting attended by General Manager, Service Managers and Team Leaders).
- 6.39 We have seen the Trust-wide Serious Incident Tracking Document with embedded lessons learnt and action plan implementation planning (discussed monthly at East Sussex Adult Services Governance Meeting, General Manager, Service Managers and Team Leaders attending):

- 6.40 We requested evidence of changes to the processing of psychology referrals and were provided with Eastbourne Assessment and Treatment Service (ATS) Psychology Team's spreadsheet record of referrals with outcomes (Jan-June 2013) which tracks outcomes and communication following referrals.
- 6.41 We were provided with the revised Eastbourne ATS team's operational protocol regarding referrals and had sight of the audit of sample extracts from the case notes and electronic records (notification letter to patients following referral, letter to patient summarising decisions, case note extract showing liaison and discussion with Substance Misuse Services (SMS) services).
- 6.42 We requested assurance that there is closer and joint working with SMS and were shown the above case note example demonstrating SMS's liaison and case discussion with psychology, other examples were available regarding joint working with other parts of Adult Services.
- 6.43 In addition we have been provided with an overview of how the dissemination of lessons from a serious incident (SI) is carried out in practice now.
- 6.44 The service manager provided us with this summary of the new process:

'For each SI, after the SI report has been scrutinised internally in the Trust and externally by the CCG and signed off, it is returned to the Serious Incident Administration office of the Trust. The report author will then liaise with the relevant general manager and service manager to discuss the findings and lessons learnt, and the identification of potential further lessons learnt and associated action planning needed and will be finalised. A decision will be made about the most appropriate way to feed- back the findings directly to the relevant clinical team(s). This may for example involve the report author attending a Team Meeting along with the service manager to discuss the findings and issues raised in the report, and meeting with individual clinicians involved when needed.

Additionally, within the East Sussex locality of the Trust, in one of the monthly Operational Governance meetings attended by the General Manager, Assessment and Treatment Service Managers and Team Leaders, and Professional Leads, there is a recurring formal agenda item concerning SI's, where lessons learnt and action plans from recent SI's are formally listed and discussed across the ATS's, any outstanding action planning needing to be implemented is identified and jointly discussed, and the written list updated accordingly for carrying forward to the next meeting. In this way the relevant operational leadership can identify any common themes concerning SI issues across the operational teams and collectively discuss potentially helpful solutions. This process started formerly at the beginning of 2013 (the current Assessment and Treatment service structure starting in October 2012, with current governance structures evolving from this point).

The incident involving SN predated these more formal governance arrangements.

The General Manager also takes a lead in discussing and monitoring SI action planning and lessons learnt implementation individually with Service Managers, who will cascade these through their respective operational teams and take responsibility for any local implementation or service delivery changes.'

- 6.45 Service managers of the ATS were able to describe the differences in practice by the relevant parts of the service as a direct result of lessons from their internal investigation.
- 6.46 The Trust has provided evidence of implementation of the Action Plan, and assurance regarding the implementation of lessons learned and governance structures that are now in place.
- 6.47 We consider that the individual action plans from this SI have been addressed, although as previously mentioned not all of the care delivery problems noted were incorporated into the internal action plan.
- 6.48 Compliance with local policies on Clinical Risk Assessment and DNA has been discussed above and concordance with NICE's guidelines for the diagnosis and management of ADHD in children, young people and adults.
- 6.49 The National Patient Safety's *Independent investigation of serious patient safety incidents in mental health services* best practice guidance¹⁹ gives considerable detailed guidance about the timely and sensitive involvement of families by a Trust.
- 6.50 Neither family was contacted by the Trust following the homicide. In the internal investigation it was reported that it was not considered appropriate.
- 6.51 The internal investigator could not recall why exactly, but with hindsight assumed it must have been because the case was *sub judice*.
- 6.52 We consider that the Trust in this instance did not involve either family appropriately.

Recommendation

Recommendation 6. Following a serious incident such as a homicide, the Trust should incorporate best practice guidance available, including the Memorandum of Understanding that exists between the Department of Health, the Association of Chief Police officers and the

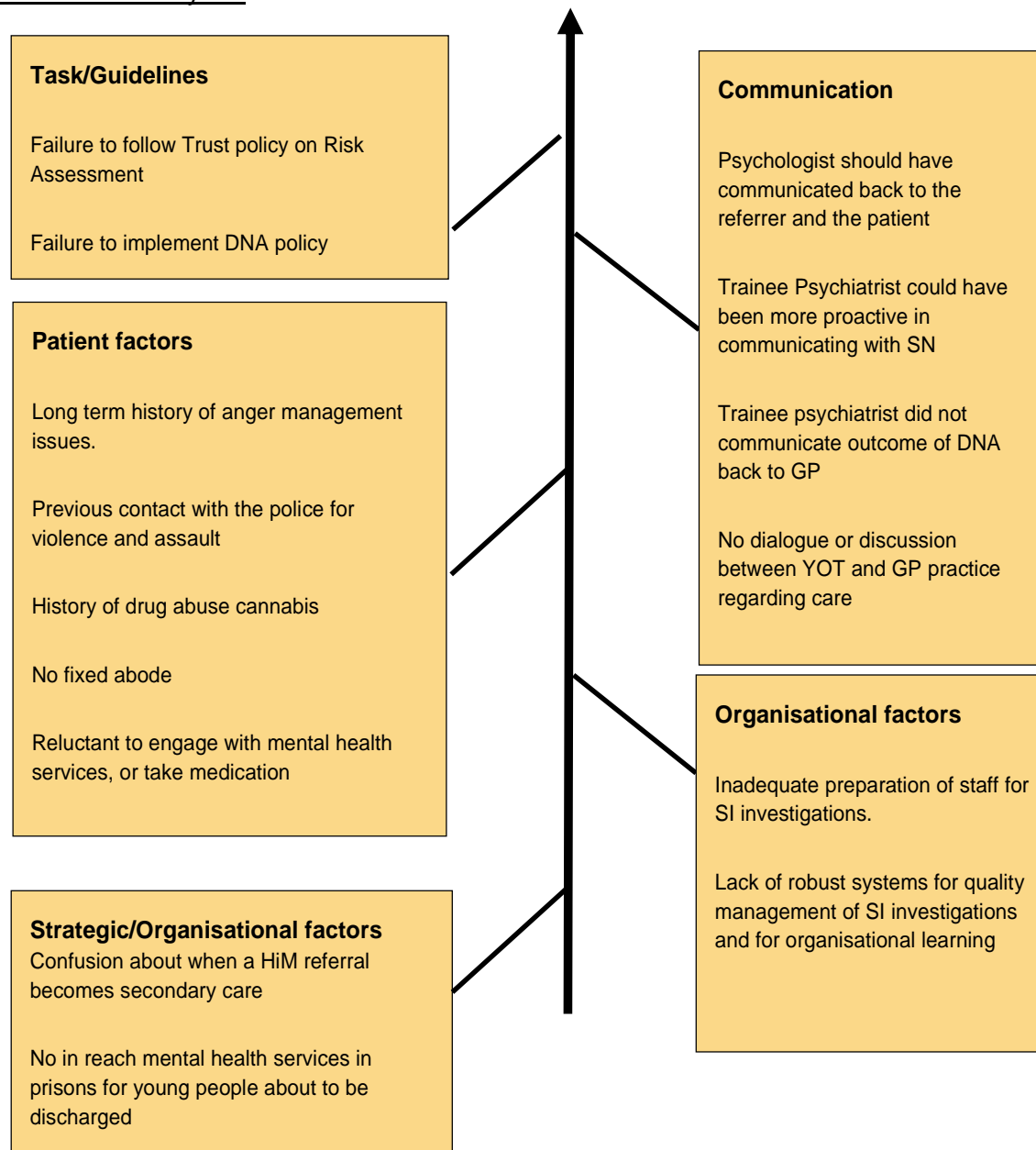
¹⁹*Independent investigation of serious patient safety incidents in mental health services provides best practice guidance on investigations into mental health services* <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836>

Health and Safety Executive. This would ensure that timely contacting with victim and perpetrator's families to agree how they would like to be engaged would be established in practice and policy. The resources of Police liaison and homicide teams, victim support or other available advocacy or support services should be used to support the process.

7. OVERALL ANALYSIS AND RECOMMENDATIONS

- 7.1 There are several ways in which the Trust and individual practitioners could have improved their understanding and engagement with SN. A more comprehensive understanding of his history and presenting mental health and psychosocial issues could have been gathered by reviewing his CAMHS notes, and his social circumstances. There was no enquiry into his homelessness, although there was recognition that support to gain employment would be helpful. Despite this, we found nothing to suggest that this incident was predictable or preventable.
- 7.2 In particular, there was recognition that there were psychological issues which may have been helped by accessing psychological support and therapy, but systems issues prevented a proper assessment and communication of outcome.
- 7.3 SN's first contact with adult mental health services was in February 2012, and this assessment by CT1N, trainee psychiatrist, focussed on his current presentation, and did not review SN's CAMHS or YOT history.
- 7.4 The structured risk assessment tools contained within the Trust's policy were not used to assess risk, instead relying on the HoNOS tool to assign a cluster and care pathway.
- 7.5 There were clear signs at assessment that SN was likely to be difficult to engage, and despite the opinion of CT1N, at the last appointment on March 2012, that his risk of violence was 'moderate and ongoing', there was no effort to recognise this with more assertive follow up, or any feedback on the outcome of the 'opt in' letter to the GP.

Fishbone Analysis



Predictability and Preventability

- 7.6 In our review of the clinical records and in the interviews that we have carried out there were no signs that could have alerted the Trust's staff that an incident of violence such as this would occur. Whilst it is clear that SN had a history of assaulting others and a pro-criminal lifestyle, nevertheless he had not come to the attention of police for violence since 2009. There were no presenting concerns that may have indicated that he was likely to be

involved in such an incident. In our opinion this incident was not predictable or preventable by any actions that the NHS should have or had taken.

- 7.7 Essentially SN became disengaged from mental health services after failing to attend the outpatient appointment in June 2012. There were concerns noted about his moderate potential for violence in the future, particularly if not taking medication regularly for ADHD. However it was recognised that he had capacity to make decisions, and that he had no motivation to reduce his substance abuse or change his lifestyle. While there could have been greater effort to try to engage him, there was no presenting concern that should have led to a more interventionist approach. SN had not come to the attention of police for any acts of violence in the previous three years, since 2009. It is notable that SN was convicted of murder, with no mental disorder taken into consideration in the legal process.
- 7.8 Although this internal investigation has highlighted some service delivery problems, these are not felt to be causal or contributory factors to the homicide.
- 7.9 The independent investigation endorses the recommendations of the internal investigation and, with the exception of recommendations about feedback from psychology assessments, we have not repeated them in our recommendations.

The following examples of good practice have been highlighted:

1. The Cookham Wood YOI In-reach service went to great lengths to establish contact with SN's GP and with the YOT, despite the geographical distance.
2. The YOT service provided a comprehensive structured service to SN on release from custody.
3. The outcome of the out patient's appointment was faxed to the GP on the same day, with a request to prescribe medication

Bibliography

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

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

<http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836>

Centre for Mental Health (2014) The Bradley Commission 2, Young adults in transition, mental health and criminal justice

http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults

National Institute for Health and Care Excellence (2008) Attention deficit hyperactivity disorder (ADHD) Clinical Guideline 72 <http://www.nice.org.uk/CG72>

Centre for Mental Health (2010) You just get on and do it, healthcare provision in youth offending teams.

http://www.centreformentalhealth.org.uk/pdfs/Centre_for_MH_Healthcare_provision_YOTs.pdf

HoNOS is the most widely used routine clinical outcome measure used by English mental health services and is an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996).

<https://www.rcpsych.ac.uk/traininpsychiatry/conferencetraining/courses/honos/whatishonos.aspx>

PbR is the payment system in England under which commissioners pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs

<https://www.gov.uk/government/publications/mental-health-payment-by-results-arrangements-for-2013->

Independent investigation of serious patient safety incidents in mental health services provides best practice guidance on investigations into mental health services <http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836>

Release and recall: Guidance for youth offending teams

<http://www.yjbstandards.org/national/resources/documents/Ref%2040%20release%20and%20recall%20guidance.pdf>

Appendix 1

Terms of Reference

- Review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the prison service and other relevant agencies from SN's first contact with services to the time of his offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment of SN in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of SN harming himself or others.
- Examine the effectiveness of the SN's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Incorporate family perspective into the TOR
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the Investigation Team that includes measurable and sustainable recommendations.
- Feedback findings to families and perpetrator
- Assist NHS England in undertaking a brief post investigation evaluation

Appendix 2

Chronology of SN's contacts with GP, CAMHS and with Secondary Mental Health Services and events leading up to the homicide

This chronology has been drawn up from medical records, prison and youth offending records and records from GP and from meeting with SN's mother and SN

Date	Source	Detail
1 1997	Mother	Diagnosis of ADHD age 4 or 5 years, mother and SN move to Eastbourne from Blackpool
1a 26/6/02	GP referral to CAMHS	Under care of CAMHSs and ADHD Nurse Consultant, seen regularly in behaviour support and Medication Monitoring Clinic.
2 5/11/02	Family Therapy team letter	Referral to family therapy by ADHD nurse, family tensions, behaviour aggressive, impulsive, swearing to family and teachers
3 9/5/03	Family Therapy team letter	Seen in family therapy centre, family feel he cannot live with them, father refused to have him, no alternatives posed, further appointments offered
4 25/6/03	East Sussex Co Council letter 25/6/03	Family support meeting with East Sussex County Council
5 21/6/04	CAMHS letter 21/6/04	Family referred for further family work by East Sussex County Council. Child protection involved because of reports SN is locked in his room from 19.00. Withdrawn on the understanding the door should not be locked- still restricted to his room after 19.00. ADHD Nurse Consultant JO'C leaves, new specialist ADHD nurse CG seen from 21/6/04
6 30/6/04	East Sussex Co Council letter 30/6/04	Unable to allocate Social Worker- referred to Maywood family centre for ongoing work
7 2/11/04	CAMHS letter 2/11/04	CAMHS consultant review- restless and impulsive, headaches on Concerta XL 54 mg. Medication changed to Strattera 25mg then 50 mg
8 20/11/04	ADHD nurse specialist letter	Medication monitoring and Behaviour Support clinic (seen monthly) Behaviour improved, Strattera 50mg
9 March 2005	Children & families locality service letter 1/3/05	Family visited by Social services once a month, couple and family therapy ongoing in conjunction with CAMHS
10 16/1/06	ADHD nurse specialist letter	Doing well on Strattera 60mg, new baby born to mother, now has two younger sisters
11 17/5/06	CAMHS letter 17/5/06	Last CAMHS letter to GP from locum consultant & ADHD Nurse specialist CG, behaviour

		challenging, frequent school exclusions, disappointing contact visits with father, referred to special needs school.
1 2006-2008	Interview with Mother	Stared to refuse to go to CAMHS appointments because he felt the new nurse upset his mother. SN behaving badly at home and school, went to live with his father in Blackpool. Came to Eastbourne on a visit in 2008 and ran away, refused to go back to Blackpool
1 2008	Interview with Mother	Mother arranged rented accommodation, but drug use in the house, so moved him. SN was offered accommodation by Social Services but refused two places because of drugs and violence in the hostels, was then regarded as intentionally homeless.
12 10/11/08	Youth offending Information system (YOIS) sentencing report	Conviction for assault by beating 2 charges – 9 month referral order (age 15yrs)
12 4/6/09	YOIS sentencing report	Conviction for burglary of a dwelling – 3 month referral order extending previous order to 12 months (age 16 years)
12 19/8//09	YOIS sentencing report	Conviction for assault by beating, threatening, abusive or insulting behaviour, criminal damage x 2, supervision order 2 years for all June/July offences (age 16)
12 19/8/09 - 23/9/09	YOIS sentencing report	Under supervision of Youth Offending Team (YOT)
12 23/9/09	YOIS sentencing report	Conviction for assault by beating, assault occasioning actual bodily harm- 12months detention order, sent to HMYOI Cookham Wood (age 16)
12 29/9/09	YOIS sentencing report	Conviction for assault by beating – conditional discharge; concurrent (age 16)
16 17/11/09	Cookham Wood In reach assessment report 17/11/09	Referred to Mental health Inreach because of anger issues, getting into fights in prison
17 10/3/10	Discharge letter mental health in reach, Cookham Wood	Diagnosis of ADHD, conduct disorder, substance misuse. Treated with Atomoxetine (Strattera) 60mg – much more settled Developed resting tachycardia, investigated and NAD but Atomoxetine changed to Methylphenidate (Concerta XL) 36 mg and Risperidone 0.5mg.
13 24/2/10	YOIS Post custody licence report	Released from HMYOI Cookham Wood, with 6 months licence order with YOT. Living with a family friend in Eastbourne. Electronic curfew at this address until 24/3/10

14 24/2/10- 22/9/10	Asset Core profile	Post custody licence supervision by YOT
14 2/10- 5/10	Asset Core profile	Seeing Connexions worker weekly for support with job search, moved to 3 times a week in 9/10 but not successful. Seen by substance misuse YOT worker regularly
15 19/3/10	GP medication summary	Prescribing restarted by GP : Methylphenidate (Concerta) XL 36mg -last prescribed Atomoxetine 60mg on 29/6/06
14 12/4/10	Asset Core profile	Re-referred to CAMHSS by YOT, SN refused to attend assessment
18 7/5/10	GP medical notes summary	Last seen by GP with mother, has had vomiting on and off since coming out of Youth Offenders, clearly didn't see it as a problem, and didn't appear to want to see GP. Currently smoking cannabis, advised of options, to return if continues
14 9/10	Asset Core profile	Extended time in Blackpool with family, missed last part of licence supervision, so breached, but signed off as completed by YOT as was very close to end timescale
14 8/9/10	Asset Core profile	YOT monitoring under licence ended
15 7/5/10- 22/6/12	GP medication summary	Intermittent prescriptions of Concerta XL
18 5/1/12	GP medical notes summary	Routine medication review by GP; had been prescribed Concerta XL for ADHD, with no specialist review of medication since discharge from HMYOI
18 23/1/12	GP medication summary	Last prescription of Concerta XL 36mg by GP
18 26/1/12	GP medical notes summary	Seen with mother for mental health review. Says Concerta makes him feel a little 'out of himself'. Occipital headaches mornings 2-3 times a week. Not sleeping well, feels tight and tense and can lose temper easily and then cannot always remember events leading to this. Getting DLA, to refer for specialist medication review
19 26/1/12	Health in Mind referral form	Referred to Health in Mind, primary care mental health service, for medication review
20 2/2/12	Health in Mind triage form	Triage by Health in Mind nurse, referred to secondary mental health service psychiatrist who consults to Health in Mind, for medication review. No risk indicators for self-harm, self-neglect or harm to others were identified. Current presentation described as problems with mood, temper, sleep pattern; often feels medication is 'clouding' him; mother tries to ensure he takes medication

21 17/2/12	Dr N outpatient assessment letter 17/2/12	Seen by Dr N (CT1 to Dr PA) as outpatient (, attended with mother. Taking Concerta intermittently, omits at weekend, getting into fights, feels drowsy, unable to function and agitated. Using between 2 and 8 grams of cannabis per day. Strongly advised to reduce cannabis, SN was reluctant to engage with substance misuse services. Started on Quetiapine 25 mg bd, Concerta discontinued. Risk assessed as neglect- low, suicide/self-harm- low, violence-low. Diagnosis ICD 10 code F90.0, F91.1, F60.2, and F12.2, Unsocialised Conduct disorder, Mental and behavioural disorder due to use of cannabinoids. HONOS 19, PBR Cluster 4ADHD Referred to Vocational team, refereed to psychology, next appointment 16/3/12
22 17/2/12	Dr N letter 17/2/12	Referred to psychology by Dr N
23 17/2/12	Dr N fax 17/2/12	Faxed medication review outcome to GP- to prescribe Quetiapine 25mg BD, Concerta XL 36mg stopped due to side effects and non-compliance
24 21/2/12	Psychology service worksheet	Handwritten outcome of conversation between Dr H (psychology) & Dr N – <i>'not accepted into service as not considered appropriate due to substance misuse and non- engagement with substance misuse services'</i> Outcome not communicated to Dr N or SN
18 24/2/12- 22/6/12	GP medication summary	Quetiapine 25 mg bd prescriptions by GP, last 22/6/12
25 16/3/12	Dr N letter 16/3/12	Seen by Dr N, with mother. Reported that he had an appointment regarding a job. Responded well to Quetiapine, sleep improved, and stayed calm for the whole meeting. Still smoking cannabis and does not want to reduce, or engage with substance misuse services. Risk assessed as neglect- low, suicide/self-harm- low, violence to others- moderate, as he has a history of violence and is unpredictable. On the waiting list for psychology, application for vocational team input completed. For next appointment in 3 months' time June 2012. Diagnosis ICD 10 code F90.0, F60.2, and F12.2. HONOS 19, PBR Cluster 4ADHD, Dissocial Conduct disorder, Mental and behavioural disorder due to use of cannabinoids. HONOOS 19, PBR cluster 0.

26 15/6/12	2/7/12 follow up letter from Dr A's secretary	Next appointment with Dr N planned
26 2/7/12	2/7/12 follow up letter from Dr A's secretary	Letter from Dr PA's secretary to SN's mothers address, did not attend on 15/6/12. Opt in letter, asking him to return request for a further appointment, informing SN if he has not responded within 3 weeks he will be discharged back to his GP.
27 4/7/12	Summary letter to HMP Lewes 24/8/12	Last contact with mental health services: SN was telephoned by the Recovery Team Vocational worker on 4/7/12- he told her that he had moved to Manchester and did not want any contact
16/8/12	http://www.bbc.co.uk/news/uk-england-sussex-19315898	Attack on man in Eastbourne who died on 17/8/12
28 20/8/12	Sussex Court liaison scheme report	Seen at Eastbourne Magistrates Court for mental health assessment, no thoughts of self-harm, and no psychosis. Recommended no need for MHA assessment, but refer to mental health services if he is remanded, for psychological interventions and medication.
6/2/13	http://www.bbc.co.uk/news/uk-england-sussex-21357694	Convicted of murder, co-defendant also found guilty
15/3/13	http://www.bbc.co.uk/news/uk-england-sussex-21807447	Sentenced to life imprisonment, to serve a minimum of 11 years,

Appendix 3 Trust SN ACTION PLAN

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
Other identified issues						
Review system for communication to all parties regarding psychology input with individuals	Team protocol to be created achieving consistent practice concerning requests for psychological therapy, especially from medics Internal protocol achieving consistent practice concerning communication with service user from the psychology team	A&T Team-wide	31 March 2013	Team Principal Psychotherapist and Service Manager	Written Protocol with 3 monthly audit	Action sent to action owner. Progress update expected 31 January 2013 From January 2013: Written Protocol regarding Psychological Therapy referrals in place and distributed to all

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						<p>clinicians in the ATS.</p> <p>Service Manager regularly attends Psychological Therapy meetings to ensure referrals are processed according to the protocol. Service Manager meets monthly with Principal Psychologist to further monitor referral process and jointly problem-solve potential</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						issues as they arise.
Psychology to provide clear rationale for decisions which should be recorded in Psychology Team Meeting referral and case discussion log book and e CPA.	Formal recording of all referrals received at weekly Psychology Team Meeting, with case discussion and decision-making, outcome and how this is fed back to referrer & service user all to be recorded in Psychology Team Meeting log book and outcome decisions entered on e CPA.	A&T Team-wide	31 March 2013	Consultant Clinical Psychologist	Service Manager to Audit Psychology Team Meeting referral process	Action sent to action owner. Progress update expected 31 January 2013 From January 2013: All psychological therapy referrals received are managed via Senior Psychologist, who oversees, actions and records all case discussion and decision making directly on eCPA, with manual recording on a

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						<p>separate excel spreadsheet.</p> <p>Service Manager regularly attends Psychological Therapy meetings to ensure referrals are processed according to the protocol. Service Manager meets monthly with Principal Psychologist to further monitor referral process and jointly problem-solve potential</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						issues as they arise.
Psychology to assess all referrals face to face			31 March 2013	Team Principal Psychotherapist and Service Manager		<p>Action sent to action owner. Progress update expected 31 January 2013</p> <p>January 2013:</p> <p>A proportion of Psychological Therapy referrals are signposted to other services if this is felt to be the</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						<p>most appropriate intervention. This decision is discussed with the referrer and the service user before being finalised, and the decision with the clinical rationale recorded. All other referrals are offered a face to face assessment with a psychologist.</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
Teams should liaise with substance misuse services more closely	<p>Meeting at Team Leader Level between Substance Misuse and Assessment & Treatment Service to examine current practice around liaison and referrals across the services</p> <p>Outcome shared within individual disciplines via team meetings within the Recovery Teams</p>	Locality based, outcome to be discussed at E Sussex Governance meeting for potential broader sharing	31 March 2013	A&T Service Manager	Minuted meetings.	<p>Action sent to action owner. Progress update expected 31 January 2013:</p> <p>March 2013:</p> <p>A&T Team Leaders and Substance Misuse Service (Action for Change) Team Leader have met to review liaison and communication, and referral processes between the two agencies.</p> <p>Agreement to continue meetings</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						<p>at least annually. Dual Diagnosis issues and joint service involvement and individual clinical issues discussed at weekly A&T and Recovery & Wellbeing Team meetings, and daily multi-disciplinary Triage Meeting if appropriate. Team and Locality-related Dual Diagnosis issues regularly discussed at General Manager/Service Manager/Team</p>

Findings	Action Required	Scope of action	To be completed by	Lead Responsibility	How to be audited?	Current Status as at (date)
Direct Findings			Date	Level	Actions	
						Leader level at monthly Governance meetings, with outcomes shared within individual ATS.
Name of Lead Contact	Service Manager, Eastbourne Assessment & Treatment Service				Date:	2nd January 2012

Appendix 4 Documents reviewed

- Clinical Risk Assessment and Management Policy and Procedure, dated January 2012.
- Active Engagement, incorporating Did Not Attend (DNA) Management, Policy and Procedure, dated May 2012.
- Adult Community Mental Health Service's Operational Policy 'Under 1 roof' ,dated June 2011;
- Adult Community Mental Health Service's Operational Policy, dated September 2011.
- East Sussex Mental Health Service's structure, dated May 2011.
- East Sussex Mental Health Service's structure dated May 2014.
- Prison and under 18s in Custody Service description undated.
- Draft CAMHS's ADHD pathway guidelines current undated
- Level 2 SI report 2012/20537, dated November 2012.
- Serious Incident Action Plan, updated January 2013;

In addition to the Trust's documents we referred to relevant national publications and guidelines, including:

- Centre for Mental Health (2014) The Bradley Commission 2; Young adults in transition, mental health and criminal justice²⁰
- National Institute for Health and Care Excellence (2008); Attention deficit hyperactivity disorder- Clinical Guideline²¹
- Centre for Mental Health (2010) Healthcare provision in youth offending teams²².
- Release and recall: guidance for youth offending teams²³

²⁰ Centre for Mental Health (2014) The Bradley Commission 2, Young adults in transition, mental health and criminal justice
http://www.centreformentalhealth.org.uk/pdfs/Bradley_Commission_briefing2_youngadults.

²¹ National Institute for Health and Care Excellence (2008) Attention deficit hyperactivity disorder (ADHD) Clinical Guideline 72
<http://www.nice.org.uk/CG72>

²² Centre for Mental Health (2010) You just get on and do it, healthcare provision in youth offending teams.
http://www.centreformentalhealth.org.uk/pdfs/Centre_for_MH_Healthcare_provision_YOTs.pdf

²³ <http://www.yjbstandards.org/national/resources/documents/Ref%2040%20release%20and%20recall%20guidance.pdf>

Appendix 5 Profile of the services

1 Sussex Partnership NHS Foundation Trust (SPT)

Sussex Partnership NHS Foundation Trust is a single Mental Health Trust providing services across three divisions; in Brighton & Hove, West Sussex and Eastbourne. Mental Health services are commissioned via the clinical commissioning group (CCG) based in East Sussex. This team works on behalf of the 3 East Sussex CCGs to commission mental health services for the population of East Sussex

East Sussex Child and Adolescent Mental Health Service (CAMHS)

The Trust's CAMHS services provide mental health care and treatment for children and young people up to the age of 18 years across Hampshire, Sussex and Kent. The service is for children and young people who are experiencing a range of emotional and mental health difficulties, working closely with families and carers as well as other services including schools, children's social care and voluntary sector organisations who offer other types of help and support. There is a local service in Eastbourne, which offers outpatients appointment with Adolescent Psychiatrists, and for ADHD there was a Behaviour Support and Medication Monitoring Clinic available, run by an ADHD Nurse Specialist.

East Sussex Adult Community Mental Health Services:

Health in Mind (HiM) is provided by the only primary care mental health service in Sussex, designed for people not on CPA, mostly in treatment by the GP. There is a HiM worker placed in the GP practices. A psychiatrist works with HiM half a day a week, to support people who may need help with medication but this is not regarded as a referral to secondary mental health services. At the time of this referral a generic Community Mental Health Team model was in place. A reconfiguration took place in October 2012, and Assessment and Treatment Centres (ATC) were established. In the current 2014 model, the person would be referred to the specialist secondary care

ATC, screened and given a priority status, then assessed and given a PbR²⁴ cluster. The treatment plan then follows on from whatever cluster is applied.

2 East Sussex Youth Offending Team (YOT)

The staffing complement of Eastbourne's YOT is recruited from the Police, Probation, Children's Services (including Education), Health and the voluntary sector. The aim of the service is to prevent offending by children and young people. The YOT supports children and young people aged 10-17 who have offended and received a final warning from the police or who have received a community or custodial sentence. The team also runs youth crime prevention programmes that target young people at risk of offending and has a number of group and individual programmes that promote life skills, coping skills and offence reduction work.

The Eastbourne team has its own substance misuse workers, vocational support workers, and a psychologist who works across CAMHS and YOT services to provide psychological input where it has been identified as being appropriate, using a structured approach to care planning and review.

3 Cygnet Healthcare CAMHS in reach service at HMYOI Cookham Wood

HMYOI Cookham Wood provides a regime for young men which is consistent with the Youth Justice Board's Strategy for Secure Estate for Children and Young People and which focuses on providing education and vocational training and reducing reoffending. In 2009 and 2010, at the time of SN's incarceration, the Mental Health In reach CAMHS provision was provided on contract by Cygnet Healthcare, Godden Green. A consultant adolescent psychiatrist, mental health nurses and CBT therapists provided mental health care when young people were referred to the service.

²⁴ PbR – 'Payment by Results (PbR) to healthcare providers was introduced to improve efficiency, increase value for money, facilitate choice, enable service innovation and improvements in quality.
<https://www.gov.uk/government/publications/payment-by-results-pbr-operational-guidance-and-tariffs>

Appendix 6 – Profile of the Investigation team

Carol Rooney, Senior Investigations Manager: Carol is a Registered Mental Nurse (RMN) of 26 years who has worked in a variety of clinical, managerial and professional lead roles in the NHS and Independent mental health sector, working extensively in Forensic services. She has significant experience of leading on clinical risk management and violence reduction, holding a patient safety role as head of clinical risk management for a national mental health charity.

Dr Mark Potter, Clinical Advisor: Mark was appointed as a Consultant Psychiatrist in November 1991 and is also an Honorary Senior Lecturer in the Department of Psychiatry, St George's Hospital Medical School, and examiner for the MRCPsych, and member of the Royal College of Psychiatrists. He has a special interest in supporting SUI investigations using root cause analysis, and has worked on over 12 investigations, including suicides and 3 homicides.

Nick Moor, Director : Nick has over 20 years health care experience, the majority of this in mental health, and is our Lead Director responsible for Homicide investigations under HSG (94) 27. An RMN by background, Nick has a thorough understanding of clinical practice and an MBA from Sheffield University. He is also passionate about patient safety and quality, and set up our patient safety team. He maintains a keen interest in the legal and ethical aspects of healthcare and has a Post Graduate Diploma in Law from Cardiff Law School in this field, and has conducted and supervised many serious incident and homicide investigations.