An independent investigation into the care and treatment of a mental health service user Ms C in Humber Teaching NHS Foundation Trust

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

Our final Report has been written in line with the terms of reference as set out in our Letter of Engagement for an independent external quality assurance review following an internal investigation into the care and treatment of mental health service user Ms C in 2019. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we find that data or information is unreliable, we will say this within our report.

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1. Executive summary

1.1 NHS England North commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user, Ms C. The requirement was also to assess the implementation of recommendations which resulted from the Trust's internal investigation. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to improve practice. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.5 This independent investigation concerns the care and treatment of Ms C (which is a pseudonym) by Humber Teaching NHS Foundation Trust. Ms C had been under the care of mental health services since 1991. In 2019 she was convicted of the manslaughter of her neighbour, Susan. The family of the neighbour have requested that we refer to her by her first name, Susan, throughout this report.

The homicide

1.6 On 21 October 2018, Susan was found deceased in her garden at her home address.

1.7 Ms C was subsequently arrested on suspicion of causing her death. After assessment she was transferred to a secure mental health unit.

1.8 Ms C admitted manslaughter on the grounds of diminished responsibility. She was detained under Section 37 of the Mental Health Act 1983 (MHA)[3] with Section 41 MHA[4] restrictions, and transferred to a secure mental health unit.

[1] NHS England Serious Incident Framework March 2015. https://improvement.nhs.uk/resources/serious-incident-framework

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

[3] Section 37 of the MHA 1983 means an individual will be sent to hospital for the treatment of a serious mental health illness, where the person is convicted of an offence publishable by imprisonment.

[4] Section 41 of the MHA 1983 means a patient cannot be discharged from hospital unless agreed by a Tribunal or the Ministry of Justice. The discharge from hospital may be subject to ongoing conditions.

1.9 We would like to express our most sincere condolences to the family and friends of Susan. We do hope that the way or the manner in which we write our report does not cause them additional distress at this difficult time.

Mental health history

1.10 Ms C had twenty five years of (often limited) engagement with two mental health teams in what is now Humber Teaching NHS Foundation Trust. Her first contact with mental health services was in 1991.

1.11 Her initial diagnosis was puerperal psychosis but she was subsequently diagnosed with Bipolar Affective Disorder (BPAD), which remained her primary diagnosis until the homicide in 2018.

1.12 Ms C had been admitted to hospital on more than 20 occasions since 1991. These admissions included several periods of detention under the MHA, an episode under the Supervision Register[5] in the early 1990's, and also two periods of care under Section 17A of the MHA, known as a Community Treatment Order (CTO)[6] in 2011 and 2016.

1.13 Following an admission to hospital January 2016 Ms C was referred to Goole community mental health services for care coordination, and was discharged from hospital in March 2016 subject to a CTO. The rationale for commencing Ms C on a CTO was due to her history of noncompliance with prescribed medications, her risk of relapse and associated risk of violence towards others when unwell.

1.14 Ms C was referred to Hull community mental health services in April 2016, her care was provided under the Care Programme Approach (CPA)[7] and she was allocated a care coordinator. At this time she was still subject to the expectations of the CTO, and was prescribed a mood stabilizer and antipsychotic medication.

1.15 Ms C's CTO was rescinded by her care team in February 2017. The rationale for stopping the CTO was Ms C's compliance with medication, that she had presented as stable, and the power of recall had not been used over the previous 12 months.

1.16 Support and monitoring of her mental health continued throughout 2017 and early 2018. There was some discussion by Ms C's MDT about discharging her from mental health services in April 2018, but this caused Ms C some anxiety

[5] Health Service Guidelines issued on 10th February 1994 required all mental health provider units to establish supervision registers by 1 April 1994 and to have them fully implemented by 1 October 1994 (NHS Management Executive, 1994). The aim of the register was to identify those people with a severe mental illness who may be at significant risk to themselves or others and ensure that they receive appropriate and effective care in the community.

[6] A Supervised Community Treatment Order (commonly a CTO) is part of the Mental Health Act. It was introduced as part of the 2007 amendments and was designed to enable some service users who are detained under longer sections of the Mental Health Act to be discharged earlier if possible, with conditions to support their stability and prevent relapse.

[7] The Care Programme Approach (CPA) framework was introduced in England in 1991 by the NHS as a form of case management to improve community care for people with severe mental illness following the introduction of the Community Care Act 1990. The guidance was reviewed and updated in 2008 and CPA now describes a higher level of care coordination support for people with a wide range of needs from a number of services, or who are at most risk.

and was not pursued. She was seen regularly by her Care Coordinator during 2018.

1.17 On 10 October 2018 Ms C called the care team asking for help, particularly with her current partner (D) who was also a service user. She told the care coordinator that the stress of her partner's mental health problems was affecting her own mental health.

1.18 Ms C's last clinical care record entry on 14 October 2018 indicated that there were no changes in respect to her risk assessment and no changes were made to her risk management plan.

Findings

1.19 Although there have been some elements of good practice with regard to Ms C's care (please see overleaf), our review has identified that there are also areas in which the delivery of care could have been improved, some of these areas are summarised as follows:

Care Planning

1.20 Throughout Ms C's care episodes with Hull community mental health services, few interventions were adjusted or implemented as changes in her needs occurred, and her community care plans were not reviewed in a timely or meaningful way. For example, the care plan was not reviewed or changed when her CTO was rescinded on 6 February 2017, and her risk assessment and care plan was not adjusted in October 2018 when she had asked for support with her partner prior to his admission to hospital.

1.21 Ms C was not offered psychological interventions to address her chronic poor insight into her illness, and to promote engagement with services and compliance with prescribed medications.

1.22 Ms C should not have been discharged from mental health services or from her Section (S117) aftercare entitlement on 16 November 2015. There had been an insufficient period of time for her care team to assess her mental state and risk (seven months) given her history.

1.23 Ms C's care plans in 2017 and 2018 were focussed on her social needs, such as claims for Employment Support Allowance (ESA). Whilst her social needs are clearly important, and would impact on her mental health, there also should have been more focus on the underlying aspects of her significant mental health and unmet psychological needs including psycho-education to support her compliance with medication. There was insufficient consideration of risk and mitigating interventions to safeguard Ms C against a relapse in mental state, or to protect others against the risk of aggression when she was unwell.

Risk assessment

1.24 There was no up to date comprehensive risk assessment, with missed opportunities for her risk assessment to be reviewed by her MDT and updated in

keeping with stipulated policy timeframes. These included when emerging risk triggers occurred in the time leading up to the incident.

We also observed an absence of robust risk interventions to monitor risk of non-compliance with her medications in the community. Although her Lithium plasma levels were meant to be taken every three months this did not happen. In fact her Lithium plasma levels were taken only twice in 2017 (instead of four times) and twice in 2018 up to October (instead of three times).

1.25 There were missed opportunities for the Community Mental Health Team (CMHT) to consult with specialist forensic services in respect of Ms C's risk assessment, despite guidance within the Clinical Risk Policy.

1.26 Ms C's risk assessment did not include consideration of how her psychological needs, such as improving her insight, could support compliance with her medication.

1.27 Ms C's relationship with a service user with unstable mental health, acted as a significant stressor for Ms C. This was never adequately considered by either care team. If she had properly been considered as a carer, and given a robust carer's assessment, her needs may have been assessed and treated more appropriately.

1.28 It is our view that the Trust needs to further develop practice and services concerning risk management and working with such challenging service users. We have made the management and documentation of risk the subject of our recommendations.

Management of the CTO

1.29 The CTO was monitored and reviewed in keeping with requirements within local policy; however, Ms C did not receive any planned medical reviews after her CTO was rescinded. We are of the opinion that the MDT did not place adequate emphasis on her longitudinal risk profile and management plan.

Medication

1.30 Ms C's prescribed medication was in keeping with NICE guidance for the pharmacological treatments recommended for BPAD. However, there were missed opportunities for her Lithium compliance to be assured aside from her Lithium plasma results and her presentation at appointments with her care team.

1.31 There were also missed opportunities for the side effects of medication to be assessed more frequently in order to assess the efficacy and validity of any changes made to medication to address unwanted side effects.

Care provision

1.32 We believe that Ms C's care was not negatively affected by being under mainstream community mental health services as opposed to a forensic community mental health team.

1.33 There was, however, a missed opportunity for her to receive a more in-depth assessment of her risk of violence towards others.

1.34 Given her history of disengagement, noncompliance and relapse, there also should have been a more robust process for monitoring medication compliance, and a more general focus on both her mental health and the impact of her relationship with D on her mental health.

Internal investigation action plan

1.35 Our assurance review team found that the Trust has progressed its action plan but some actions are yet to be tested or embedded.

Recommendations to improve practice

1.36 We have made the following six recommendations to improve practice:

Recommendations

Recommendation 1
The Trust should align the "Care Programme Approach (CPA) and Non CPA Policy and Procedural Guidance" and the "Operational Guidance, Hull Adult Community Mental Health Teams" so that staff are clear about the factors that must be taken into account when discharge from services has been requested or is being considered, and the operational protocols to be followed when discharge has been agreed, especially for those service users with a history of violence.

Recommendation 2
The Trust must assure itself that risk assessments and CPA documentation are kept up to date, and are of the appropriate quality, in line with Trust policies.

Recommendation 3
The Trust should consider, and reference in appropriate policies, the need for additional methods of monitoring compliance with Lithium to mitigate the risks of non-concordance with treatment plans for patients with a history of noncompliance and who are at risk of relapse.

Recommendation 4
The Trust must update the "Operational Guidance, Hull Adult Community Mental Health Teams", to clarify the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service user's care should be sought. The Trust must assure itself that this revised guidance is being followed.

Recommendation 5
The Trust should seek to agree with the police how and when it can engage with families who have been affected by a mental health homicide.

Recommendation 6
The Trust should evaluate the evidence underpinning its action plan within three months to ensure it can demonstrate to the CCG that each action has been completed, tested and embedded. In instances where actions cannot be evidenced as closed, steps should be taken to fulfil the original commitments of the action plan within six months.[8]

Notable practice

1.37 During the transfer of care from Goole to Hull, we found that Goole services continued to see Ms C for a protracted period, although she should have been care coordinated by Hull. Hull services had significant capacity difficulties at that time and Goole supported Hull services. This meant that Ms C continued to receive support in the community until a care coordinator was finally allocated. This enabled her to have a seamless transition between services.

[8] This is a residual recommendation pertaining to the Trust internal investigation action plan. We discuss this in section 7, 'Implementation of action plan'

1.38 In 2016 when Ms C's serum Lithium levels were found to be suboptimal, the increased frequency of monitoring, at three weekly intervals, in order to try to maintain a more therapeutic serum Lithium level was notable practice.

1.39 Ms C's Care Coordinator made significant efforts to ensure that their therapeutic relationship continued, despite the difficulties that Ms C's illness caused to her engagement with mental health services.

1.40 The Trust attempted to fulfil their Duty of Candour obligations to Susan's family, despite the police refusal to share contact details. They made contact with Susan's family at the earliest opportunity afforded to them once they were provided with the family contact details.

2. Independent investigation

Ms C's contact with mental health services leading up to the homicide

2.1 Ms C had been in contact with mental health services since 1991. She had a history of relapses in her mental health, often precipitated by personal stress, which were then followed by disengagement from services and noncompliance with her medication. These often resulted in a rapid deterioration of her mental state followed by admission to hospital, and then further continued support in the community. Apart from three brief admissions all of her care had been provided by Humber Teaching NHS Foundation Trust or its predecessor organisations.

2.2 Ms C had been admitted to hospital on more than 20 occasions since 1991. These admissions included several periods of detention under the MHA, an episode under the Supervision Register[9] in the early 1990's, and also two periods of care under Section 17A of the MHA, known as a Community Treatment Order (CTO)[10] in 2011 and 2016.

2.3 From 2016 up to October 2018 Ms C was under the care of Hull CMHT West, provided by Humber Teaching NHS Foundation Trust. She was removed from her CTO in March 2017 as she had been compliant with her medication and engaging with mental health services for nearly a year. She was prescribed Lithium Carbonate[11] as a mood stabiliser, and Zuclopenthixol Decanoate,[12] an antipsychotic medication given as a depot injection.[13] Her depot injection was changed to oral anti-psychotic medication in May 2017 as she had reported (and been observed to have) extra pyramidal side effects (EPSEs).[14]

2.4 From March 2017 she was supported by her Care Coordinator (CCO) through home visits, and her medication was monitored by blood tests taken by the GP to establish the therapeutic level of Lithium. Ms C also received support concerning her benefits after an allegation of benefit fraud was raised by the Department of Work & Pensions (DWP).

2.5 Ms C was in a relationship with a fellow service user (D) and this was reported to be turbulent. Ms C had phoned her CCO on 10 October 2018 asking for help for D who was admitted to a Psychiatric Intensive Care Unit (PICU) on 14 October

[9] Health Service Guidelines issued on 10th February 1994 required all mental health provider units to establish supervision registers by 1 April 1994 and to have them fully implemented by 1 October 1994 (NHS Management Executive, 1994). The aim of the register was to identify those people with a severe mental illness who may be at significant risk to themselves or others and ensure that they receive appropriate and effective care in the community.

[10] A Supervised Community Treatment Order (commonly a CTO) is part of the Mental Health Act. It was introduced as part of the 2007 amendments and was designed to enable some service users who are detained under longer sections of the Mental Health Act to be discharged earlier if possible, with conditions to support their stability and prevent relapse.

[11] Lithium Carbonate (Lithium) is a mood stabiliser typically used to treat mania and depression. It has a narrow therapeutic range and can be toxic in too high concentration in the blood, and ineffective if too low.

[12] Zuclopenthixol decanoate is prescribed for maintenance in schizophrenia and paranoid psychoses.

[13] Depot medication: Slow release medication often administered by injection.

[14] Extra pyramidal side effects are the side effects of neuroleptic/ anti-psychotic medication and include tremor, slurred speech, akathisia, dystonia, anxiety, distress, paranoia.

2018 after suffering a relapse of his own mental health problems. D visited Ms C at her home on 21 October 2018 after he was given leave from the PICU.

2.6 On 21 October 2018, Susan was found deceased in her garden at her home address. Susan's cause of death was attributed to a blunt force trauma. Ms C was subsequently arrested by the police on suspicion of causing her death. After assessment in the police station she was then transferred to a secure mental health unit.

2.7 Ms C admitted manslaughter on the grounds of diminished responsibility. She was detained under Section 37 MHA [15] with Section 41 MHA[16] restrictions and transferred to a secure mental health unit.

Approach to the investigation

2.8 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to reduce the chance of recurrence.

2.9 The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring. The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.10 The independent investigation follows the NHS England Serious Incident Framework (March 2015) and the Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.11 The investigation was carried out by Nick Moor and Rebecca Gehlhaar with expert advice provided by Dr John McKenna, retired Consultant Forensic Psychiatrist. The investigation team will be referred to in the first person in the report. The assurance review was undertaken by Kathryn Hyde-Bales, Associate Director, from Niche.

2.12 The report was peer reviewed by Emma Foreman, Associate Director, Niche.

2.13 The investigation comprised a review of Ms C's clinical records, associated documents, and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[17] We also referred to written records from the Trust, Ms C's GP, multi-agency safeguarding meetings, Trust policies and guidelines, and the Trust's 72-hour review and serious incident investigation.

[15] Section 37 of the MHA 1983 means an individual will be sent to hospital, as opposed to prison, for the treatment of a serious mental health illness, where the person is convicted of an offence publishable by imprisonment.

[16] Section 41 of the MHA 1983 means a patient cannot be discharged from hospital unless agreed by a Tribunal or the Ministry of Justice. The discharge from hospital may be subject to ongoing conditions.

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

2.14 A full list of all the documents reviewed is at Appendix B.

2.15 As part of our investigation we interviewed by phone and/or in person the following members of Trust staff:

- Ms C's CCO at the time of the homicide.
- Ms C's first CCO in Hull CMHT.
- Ms C's CCO from Goole's CMHT.
- Ms C's Responsible Clinician.
- The Trust's Serious Incident Investigation Team for the internal report.
- The Assistant Director for Quality Governance and Patient Safety.
- The team leader for Ms C's Community Mental Health Team at the time of the homicide.

2.16 We would like to thank members of staff for their help and co-operation during this investigation. We have endeavoured to work with all of the information which was available to the investigation team at the time.

2.17 The draft Report was shared with the Trust. This provided the opportunity for those services that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Ms C and her family

2.18 Ms C is currently receiving care in a medium security hospital. We contacted Ms C via her care team at the hospital in the summer of 2019, but it was not clinically appropriate to interview her at that time.

2.19 Ms C's care team contacted us in the new year and we arranged to meet Ms C on 5 February 2020. When we met we discussed our role and the purpose of the investigation. Ms C said she did not want her family involved in the investigation process.

2.20 Ms C agreed to meet us again to discuss the investigation terms of reference and the draft report and its findings. This meeting was scheduled to take place in March 2020 but was later cancelled owing to Ms C being unwell.

2.21 At the time of writing, we have been advised by Ms C's care team that it is not clinically appropriate to visit her. We will continue to revisit this with a view to sharing the report with Ms C prior to publication.

Contact with the victim's family

2.22 We met Susan's family on 4 November 2019, supported by a representative from the charity, Hundred Families. We discussed the purpose of the investigation and

the family contributed to the terms of reference. We agreed with the family the frequency and means of contact during the investigation.

2.23 Susan was 64 years old when she died. Susan's tragic and untimely death devastated her family and shocked her friends and neighbours in her local community. She was described as a much-loved member of the community and had a close relationship with her daughter and former husband. A friend described Susan as her closest friend, and they saw each other on most days. In the later part of their friendship, they worked together as volunteers on City of Culture projects.

2.24 Her friend described Susan as an exceptionally kind person, who was well liked and respected and would do anything for anyone. Susan was an avid gardener and had 'the best garden in Hull'. Susan is sorely missed by her many friends.

2.25 We had two update phone calls with the family during the investigation. We also met with them via Microsoft Teams at the end of May to share the findings of the draft report with them. They were supported in this meeting by Hundred Families charity.

2.26 We would like to extend our gratitude to Susan's family and friends for their involvement in the investigation process whilst at a very difficult time for them.

Humber Teaching NHS Foundation Trust

2.27 Humber Teaching NHS Foundation Trust provides a broad range of community and inpatient mental health services, community services (including therapies), learning disability services, healthy lifestyle support and addictions services to people living in Hull, the East Riding of Yorkshire, Whitby, Scarborough, and Ryedale.[18]

Structure of the report

2.28 Section 3 describes Ms C's social and family background,and her contact with mental health services.

2.29 Section 4 examines the issues arising from the care and treatment provided to Ms C and includes comment and analysis.

2.30 Section 5 reviews the Trust's enactment of the Duty of Candour during their internal investigation, and Section 6 sets out our overall analysis and recommendations.

Section 7 reports on the progress made in addressing the organisational and operational matters identified in the internal investigation.

[18] www.humber.nhs.uk

3. Summary of social, family and mental health history

3.1 Ms C was born in Goole in 1963 and into a large family.

3.2 Ms C left school at the age of 19, having attained O levels and A levels, and went top university. She proceeded to study Sociology and attained a degree.

3.3 She has been married.

Contact with mental health services

3.4 Ms C had twenty five years of (often limited) engagement with two mental health teams in what is now Humber Teaching NHS Foundation Trust. Her first contact with mental health services was in 1991.

3.5 Her initial diagnosis was puerperal psychosis but she was subsequently diagnosed with Bipolar Affective Disorder (BPAD), which remained her primary diagnosis until the homicide in 2018.

3.6 Ms C had been admitted to hospital on more than 20 occasions since 1991. We highlight some of these below. These admissions included several periods of detention under the MHA, an episode under the Supervision Register[19] in the early 1990's, and also two periods of care under Section 17A of the MHA, known as a Community Treatment Order (CTO)[20] in 2011 and 2016.

3.7 Ms C assaulted her husband in 2010 and also attempted to bite the police when they attended. She was admitted to hospital and they found that she had stopped taking her medication before this incident.

3.8 Ms C relapsed in 2011 and was admitted to hospital under Section 3 MHA. Her relapse was attributed to noncompliance with Lithium and the stress of a family funeral. Ms C was discharged back to the community in October 2011.

3.9 Ms C was readmitted to hospital under Section 3 MHA in May 2012. Ms C had damaged the property in the family home and been physically aggressive. The clinical records indicated Ms C had been noncompliant with Lithium. Her medication was also found in the garden whilst she was an in-patient, suggesting further noncompliance

3.10 In 2013 her medication was changed from Aripiprazole[21] to Olanzapine.[22] Ms C relapsed and was admitted to hospital under Section 3 MHA in April 2013. The relapse was attributed to noncompliance with Lithium medication. Though

[19] Health Service Guidelines issued on 10th February 1994 required all mental health provider units to establish supervision registers by 1 April 1994 and to have them fully implemented by 1 October 1994 (NHS Management Executive, 1994). The aim of the register was to identify those people with a severe mental illness who may be at significant risk to themselves or others and ensure that they receive appropriate and effective care in the community.

[20] A Supervised Community Treatment Order (commonly a CTO) is part of the Mental Health Act. It was introduced as part of the 2007 amendments and was designed to enable some service users who are detained under longer sections of the Mental Health Act to be discharged earlier if possible, with conditions to support their stability and prevent relapse.

[21] Aripiprazole is an antipsychotic medication. https://bnf.nice.org.uk/drug/aripiprazole.html

[22] Olanzapine is an antipsychotic medication. https://bnf.nice.org.uk/drug/olanzapine.html

discharged back to the care of community mental health services in June, Ms C was re-admitted five days later under Section 3 MHA for a further six weeks, after being hostile and aggressive and showing symptoms consistent with mania.

3.11 In May 2014, Ms C assaulted a friend by hitting her on the head with a bottle. The police attended the incident and had to intervene using protective equipment. Ms C presented as violent towards the police; she was 'tasered'[27] and had to be restrained.

3.12 Ms C was admitted to the PICU in October 2014. She had been found in a stranger's house. The police attended, Ms C was again physically violent towards them and they used a taser to manage her violent behaviour; she was later convicted of battery following these events. She was again reported to have been noncompliant with medication before her admission.

3.13 Ms C was discharged in January 2015. The discharge letter specified that noncompliance and stress were risk factors for relapse.

3.14 Ms C was admitted to hospital under Section 3 MHA in January 2016, her twentieth admission. She had been arrested after attempting to run a police officer over with her car. She had then barricaded herself in the car and had assaulted three police officers when they had tried to arrest her. Ms C was initially admitted to an out of area PICU bed, but transferred to Westlands, a female in-patient assessment and treatment unit in Hull.

3.15 Following this admission Ms C was referred to Goole community mental health services for care coordination, and was discharged from hospital in March 2016 subject to a CTO. The rationale for commencing Ms C on a CTO was due to her history of noncompliance with prescribed medications, her risk of relapse and associated risk of violence towards others when unwell.

3.16 Ms C was referred to Hull community mental health services in April 2016, her care was provided under the Care Programme Approach (CPA)[23] and she was allocated a care coordinator. At this time she was still subject to the expectations of the CTO, and was prescribed a mood stabilizer and antipsychotic medication.

3.17 Ms C's CTO was rescinded by her care team in February 2017. The rationale for stopping the CTO was Ms C's compliance with medication, that she had presented as stable, and the power of recall had not been used over the previous 12 months.

3.18 Support and monitoring of her mental health continued throughout 2017 and early 2018. There was some discussion by Ms C's MDT about discharging her from mental health services in April 2018, but this caused Ms C some anxiety and was not pursued. She was seen regularly by her Care Coordinator during 2018.

[23] The Care Programme Approach (CPA) framework was introduced in England in 1991 by the NHS as a form of case management to improve community care for people with severe mental illness following the introduction of the Community Care Act 1990. The guidance was reviewed and updated in 2008 and CPA now describes a higher level of care coordination support for people with a wide range of needs from a number of services, or who are at most risk.

3.19 On 10 October 2018 Ms C called the care team asking for help, particularly with her current partner (D) who was also a service user. She told the care coordinator that the stress of her partner's mental health problems was affecting her own mental health.

3.20 Ms C's last clinical care record entry on 14 October 2018, seven days prior to the homicide on 21 October 2018, indicated that there were no changes in respect to her risk assessment and no changes were made to her risk management plan.

3.21 On 21 October 2018, D visited her at home. The homicide occurred later the same day and Ms C was subsequently arrested.

4. Care and treatment of Ms C

Summary of contact with Trust services

4.1 Ms C had contact with three different NHS Trusts over the course of 27 years, from the age of 27 to 55 years old.

4.2 Of these 27 years, most of Ms C's care was provided by Humber Teaching NHS Foundation Trust.

4.3 Ms C had two short admissions to other services, York Health Services NHS Trust and Tees, Esk and Wear Valleys NHS Foundation Trust.

4.4 Ms C spent 47 days in the community with no care from mental health services between 18 November 2015 and 4 January 2016. Ms C was taken back under the care of mental health services following an attempt to run over a police officer with a car and was subsequently admitted to hospital.

Dates of involvement with services	Service	Outcome
3 October 1991	York Health Services NHS Trust	One day admission to mother and baby unit.
20 November 1991 to 27 April 2015	Humber Teaching NHS Foundation Trust	Goole inpatient and community mental health services. Ms C had 14 inpatient admissions during this time and was subject to a CTO between January and June 2011.
27 April 2015 to 18 November 2015	Humber Teaching NHS Foundation Trust	Hull community mental health services. Ms C was treated in the community throughout this period. Ms C was discharged to her GP on 18 November 2015.
4 January 2016 to 13 January 2016	Tees, Esk and Wear Valleys NHS Foundation Trust	The CRT received a phone call advising Ms C had attempted to run over a police officer with her car. Ms C was initially admitted to an out of area PICU in Yorkshire and later transferred to a PICU at Humber Teaching NHS Foundation Trust.
13 January 2016 to 21 October 2018	Humber Teaching NHS Foundation Trust	Ms C was transferred and admitted to PICU on 13 January 2016. She was re-referred to Hull community mental health services and was subject to a CTO between March 2016 and February 2017.

Assessment, Care planning and the Care Programme Approach

4.5 The Care Programme Approach[24] (CPA) is a framework employed by mental health services to ensure that people diagnosed with mental health difficulties receive an individualised care package tailored to meet their biological, psychological and social care needs.

4.6 The Trust's CPA and Non-CPA Policy[25] describes the five components of CPA as:

- Assessment - a multidisciplinary/multiagency assessment of the service user's needs and risks (including vulnerabilities and strengths); and assessment of risk using validated tools approved for organisational use.
- Planning of care and treatment - care plan to be developed with the service user and carer if possible, to meet the agreed outcomes which will address the identified needs and the management of identified risk (including vulnerability). This includes achieving maximum individual potential. Additionally, a 'contingency plan' (risk and relapse/long term safety plan) needs to be formulated which indicates personalised signs and symptoms of relapse and contact details for how the service user and/or carer can contact services both in and outside of normal working hours.
- Delivery of care and treatment - in line with the plan, and where applicable, coordination with other services.
- Monitoring and review - reviewing the care provided and delivery of services on a regular basis to ensure it continues to meet service user's needs. Also, there is a need to ensure the expected outcomes have been achieved, and where necessary revising the plans for delivery of care and treatment.
- Discharge/transfer - the planning for (from the beginning of entry to service) and constructive discharge of the service user from secondary mental health services when they no longer require the intervention of any such service.

4.7 The Policy states that a CPA review must be completed at least annually, and that the Trust's CPA documentation must be completed as part of this process (e.g. care plan document and risk assessment tool).

4.8 In respect of carers and the CPA, and in keeping with The Care Act (2014)[26], the Policy says they must be offered a carers assessment in order to identify any of

[24] The CPA framework was introduced in England in 1991 by the NHS as a form of case management to improve community care for people with severe mental illness following the introduction of the Community Care Act 1990. The guidance was reviewed and updated in 2008 and CPA now describes a higher level of care coordination support for people with a wide range of needs from a number of services, or who are at most risk.

[25] Care Programme Approach (CPA) and Non-CPA Policy and Procedural Guidance (M-020) Humber Teaching NHS Foundation Trust (2017).

[26] An Act to make provision to reform the law relating to care and support for adults and the law relating to support for carers. *www.legislation.gov.uk/ukpga/2014/23/section/27*

their needs and should be signposted to services for support in circumstances where the CCO is unable to provide the type of service or help that they require.

4.9 The CPA Policy does not describe the detail of what should be included in an individual care plan; however, it refers to the care planning guidance and structure in the electronic patient records. There is an assessment template in the electronic record which includes:

- mental health needs;
- children within the family;
- faith and belief;
- language;
- nutrition/physical health;
- self-care and mobility;
- personal finances;
- accommodation/environment;
- occupational/recreational activity; and
- family and carer support needs.

4.10 Additionally, a Contingency Plan (risk and relapse/long term safety plan) is to be formulated which indicates personalised signs and symptoms of relapse, with contact details for how the service user and/or carer can contact services both in and outside of normal working hours'.

4.11 Care plans should be developed and reviewed at CPA review meetings attended by the professionals involved, the patient and carers.

4.12 Approaches to care planning should also be informed by best practice guidance, which is published nationally. NICE guidance[27] provides evidence-based recommendations developed by independent committees, including professionals and lay members, and which are consulted on by stakeholders. Good practice suggests that where an individual has a particular diagnosis and areas of identified need, the NICE guidance standards would be used to guide care planning.

4.13 In Ms C's case the relevant guidance would be the NICE clinical guideline for 'Bipolar disorder: assessment and management' (CG185)[28] which was published in 2006, then updated in September 2014.

[27] NICE guidance is produced by topic, and there is published guidance on a range of mental health and behavioural conditions. https://www.nice.org.uk/guidance

[28] NICE Clinical guideline [CG185] Bipolar disorder: assessment and management (2014).

4.14 There are quality statements about best practice in care and treatment, and we have commented on the relevant sections of these in relation to Ms C's care as outlined below.

4.15 We have been asked to review Ms C's involvement with services at the point of transfer to Hull mental health services in April 2015 until the homicide on the 21 October 2018.

4.16 Ms C was first diagnosed with puerperal psychosis in 1991, post-partum depression in August 1993, schizophreniform psychosis or schizophrenia in February 1996, and BPAD (by the Professor of Psychiatry) in August 1996. From February 2009 onwards, she had an established diagnosis of BPAD.[29] In April 2016, a locum psychiatrist who had not previously seen Ms C ascribed a diagnosis of 'personality disorder'.

4.17 Ms C was transferred from Goole CMHT to Hull CMHT West in April 2015. At the date of transfer, 27 April 2015, actions identified to meet her needs were assessed as '*continuing to monitor Miss C's mental health until her new team was available. Monitor mood, sleep, appetite and any risk. Also monitor medication. Ms C is on Lithium and needs her bloods taking regularly'*. At this time, it was also identified that she required a follow up outpatient appointment with a Psychiatrist, which had occurred prior to transfer. This care plan was dated 10 February 2015 and was identified as valid until 10 May 2015. The Goole transfer care plan contained little historical information, making it harder to ensure the CPA process was underpinned by the new team.

4.18 There was also a Relapse and Risk Management Plan dated 10 February 2015 which included personalised relapse signs and symptoms and action to be taken by the patient or carer in the event of relapse/risk.

4.19 Ms C and her new CCO were both present at the handover of care. The documentation shared at the time was up to date and contained comprehensive detail about Ms C's history. For example, in respect of Ms C's well-established risk of noncompliance with medication and associated risks including relapse in mental state and increased risk of violence and aggression towards others.

4.20 The 'transfer of care document' was completed at the CPA review; however, the care plan in place at this time does not meet the CPA standards required as it does not identify assessed needs and risks.

4.21 Following the transfer to Hull CMHT West we could not find any evidence of a care plan in place. This would suggest a breach of the CPA and Non-CPA Procedural Guidance.

4.22 In May 2015 Ms C was found by police on railway tracks, with superficial cuts to her hands and arms. This incident resulted in the involvement of the crisis service, however, the February 2015 care plan was not reviewed or updated following this.

[29] 2020 ICD-10-CM Diagnosis Code F31.9 Bipolar disorder, unspecified

4.23 There is also no assessment documentation following transfer and no further CPA documentation up until 21 September 2015 when a CPA review was held and a 'joint services review form' completed. The form identified this as a S117 meeting, but no outcomes were recorded in the clinical record. A further CPA discharge review was held on 16 November 2015, where a decision was taken to take Ms C off CPA and S117. The risk assessment document was updated and Ms C was discharged from S117 aftercare on 16 November 2015.

4.24 S117 MHA sets out the responsibility to provide aftercare following detention under certain MHA sections including Section 3. It states that:

'It shall be the duty of the clinical commissioning group or Local Health Board and of the local social services authority to provide in co-operation with relevant voluntary agencies, after-care services for any person to whom this section applies until such time as the clinical commissioning group or Local Health Board and the local social services authority are satisfied that the person concerned is no longer in need of such services but they shall not be so satisfied in the case of a community patient while he remains such a patient'.

4.25 The discharge process complied with the CPA Procedural Guidelines. However, we found that guidance within the CMHT Operational Guidance advised that discharge from the service could be arranged if there were difficulties with the patient engaging with services. As previously referenced, the CPA Policy in use at the time instructed that a patient may only be discharged from the Trust if they no longer required support from any part of the mental health services, which is not reflected in the CMHT procedure.

4.26 At the point of discharge in November 2015, Ms C had been under the care of Hull mental health services for less than seven months. The team had received clinical information pertaining to Ms C's mental health history from Goole services which included an extensive list of psychiatric inpatient admissions. The majority of these psychiatric inpatient admissions had been triggered by poor engagement with services (including that she had been previously subject to a CTO), poor compliance with her medication regime and often resulted in significant acts of violence and aggression towards others.

4.27 The CPA Procedural Guidance states that 'every effort must be made to develop/present a care plan that is acceptable to the individual'. There is no evidence of this within the clinical notes, and there was no care plan in place.

4.28 Ms C had significant mental health needs. There were frequent reports of concern by her family and D. Visits by staff identified signs from her relapse signature and these resulted in MHA assessments being arranged. These included a report of Ms C waving a knife, police finding her on railway tracks with cuts to her hands and arms, sofa surfing, refusing to engage with her GP and noncompliance with prescribed medication. Ms C had often disengaged from her care team.

4.29 In our opinion there was an insufficient period of time in which to inform her care team's assessment prior to Ms C being discharged. Ms C's last risk assessment completed by CCO2 on 18 November 2015 included detail of her history of

violence and aggression towards others when 'psychotically unwell'. At the time of discharge Ms C had been under a neighbourhood nuisance team for displaying verbally confrontational behaviour towards others, but the assessment said that the team did not have plans to 'take action'. The risk assessment said that, 'these more recent examples [contact with the neighbour nuisance team] of antisocial behaviour do not appear to have escalated and seem more a reflection of her personality traits than the effects of psychosis'. This opinion suggests that the care team considered that Ms C was choosing to behave antisocially, and that accordingly such behaviours might not be regarded as indicating a need to consider whether or not she might be exhibiting symptoms of a relapsing mental disorder. In turn, this approach may well have contributed to the team's decision to discharge.

4.30 There was little evidence of any discussion in respect of managing her risk of relapse or consideration of any safeguards in the context of risk of violence and aggression towards others, outside of advice to her GP to re-refer her to community mental health or crisis team services. Furthermore, the risk assessment said Ms C was to be 'discharged with some expectation that she will come to the attention of mental health services again' suggesting that Ms C did have mental health needs at the point of discharge.

4.31 Given her previous history and the aggressive incidents that occurred when she relapsed, we would have expected to see a longer period of engagement and tapering off of community care to establish that Ms C was able to live in the community independently of mental health service input. Given her complexity we also believe that she would have fitted the criteria for the Trust's approach to complex cases,[30] which may have provided a more robust framework for managing her care.

4.32 On 4 January 2016 Ms C was arrested for attempting to run a police officer over with her car. Ms C had barricaded herself in the car and had assaulted three police officers when they had tried to arrest her. Ms C was initially admitted to hospital in Scarborough under Section 2 MHA but was transferred back to local inpatient services where she was then transferred to Section 3 MHA. Ms C was referred to Hull community mental health services and was discharged from hospital subject to a CTO on 12 March 2016.

4.33 Before discharge from hospital, a pre-discharge review meeting was held in keeping with CPA Guidelines and a CTO Rights Care Plan was completed by ward staff, but this document was not dated. There was no care plan evident from this meeting, contrary to the Trust CPA Guidance.

4.34 On discharge from hospital Ms C was allocated to CCO3 who maintained care coordination responsibilities until 21 October 2018.

4.35 After Ms C's detention under Section 3 MHA, her needs were assessed as:

[30] Managing Inpatient and Community Complex Cases for the Mental Health Care Group: A stepped approach to provide support to Inpatient and Community services, 2018.

- maintaining compliance with her medication to sustain mental wellbeing;
- promoting social inclusion in respect of her occupational and recreational difficulties due to social withdrawal; and
- self-care and mobility after Ms C had sustained fractures to her foot and ankle whilst attempting to abscond from hospital.

4.36 The conditions of the CTO for Ms C were that she should:

- make herself available for regular reviews at the Waterloo Centre (where her CMHT were based);
- make herself available for regular home visits or clinical reviews at the Waterloo Centre with CCO3 and/or by other members of the Hull CMHT West; and,
- accept prescribed Lithium medication on a daily basis for mood stabilising properties.

4.37 A care plan was completed on 18 May 2016 by Ms C and CCO3. The areas of need identified were in respect of; mental health needs, nutrition and physical health, self-care and mobility, personal finances, accommodation/ environment, and occupation/recreational activity.

4.38 There is no reference to the CTO within the care plan and it is stated within the care plan that this should be reviewed within one month of discharge. In this case it was two months before the care plan was written.

4.39 Ms C's relapse and risk management plan was completed on the 26 July 2016. No relapse and risk management plan was completed after this date.

4.40 Her relapse signature included:

- pressure of speech;
- flight of ideas;
- marked increase in grandiosity;
- increased aggression;
- speaking in French;
- disengagement from services;
- isolation; and
- non-concordance with treatment plan.

4.41 There was a contingency and crisis plan that involved:

- medication review;
- increase face to face contact;
- encourage compliance with medication and monitor response;
- monitor stability of mental health;
- review Risk Assessment and Care Plan;
- joint home visit with Consultant Psychiatrist;
- referral to Rapid Response Team; and
- consider MHA assessment.

4.42 The CPA review held on 16 August 2016 incorporated a CTO review which was in line with CPA guidance. It was identified that there was a need for Ms C to receive psychoeducation into her diagnosis in order to improve her insight, to support increased engagement with services and her treatment plan, and that this would be provided by her care team. This was not added to the care plan.

4.43 A review of her CTO was completed on 6 February 2017, where the CTO was rescinded.

4.44 Ms C's care plan and risk assessment should have been updated and a more robust risk management plan should have been implemented in respect of medication compliance when her CTO was rescinded. Given Ms C's long history of noncompliance with medication, and the severe and rapid deterioration in her mental health (and risks to others) associated with such instances of noncompliance, we would have expected that her care and risk management plan would have been updated to include closer and more robust monitoring of her medication compliance.

4.45 Ms C was described as compliant with her medication treatment plan and had demonstrated a period of stability over the course of the CTO, evidenced by her not requiring any psychiatric admissions throughout this period of her care by Hull CMHT West. There was no update to Ms C's care plan and no evidence of a CPA review to coincide with the CTO review.

4.46 A CPA review was held on the 16 August 2017 with Ms C and CCO3 present. The outcome of the review indicated no significant changes to her care interventions. There was no update to her care plan following this.

4.47 Ms C's care plan was updated on 27 December 2017 and contained a contingency section and relapse signature. This is the care plan in place at the time of homicide but there was no evidence of a CPA review taking place. There were no tangible mental health needs identified within the 'needs section' of the report.

4.48 Ms C's care plan identified that she had been discharged from her CTO on 6 February 2016 due to stability in mental health and concordance with her Lithium treatment plan. Interventions identified to meet her needs were recorded as: for Ms C to remain concordant with her treatment plan, to attend her GP for Lithium blood monitoring and to collect her prescriptions from the pharmacy. We would have expected to see detail pertaining to her chronic history of noncompliance with medication and associated relapses in mental state. We would also have expected to see an exploration of the causes for noncompliance with medication and the identification of impaired insight into her illness. Ms C's care plan should have included more robust interventions by her care team to mitigate against future relapses in mental state, attributed to noncompliance of her prescribed medications.

4.49 CC03's interventions were identified as:

- to review treatment plan with RC and to monitor for signs of risk, relapse or side effects;
- to maintain 3-4 weekly face to face contacts, to monitor Ms C's mental health, safety, risk and emotional wellbeing with a view to offer support as appropriate should there be any evidence of risk or relapse;
- to support Ms C with correspondence from DWP; and
- to support Ms C with social activities …"

4.50 We have not seen any evidence that the care plans and relapse risk management plans had been reviewed in line with the CPA Procedural Guidelines and, whilst some documents are in compliance with Trust guidance overall, there are areas which could be improved.

4.51 For example, whilst the care plans contained social interventions, they did not clearly identify any psychological interventions/psychoeducation. There was a missed opportunity to provide a robust care plan to adequately meet Ms C's needs and keep her well.

4.52 The care plans do not identify the legal status (CTO) or the conditions to be adhered to, or any difficulties in engagement or compliance with medication which is identified within the clinical record.

4.53 Throughout Ms C's relapse and risk management plans, it is identified that social stressors increase her risk of relapse. These were initially identified as: the recent end of her marriage, moving accommodation out of area, beginning a new relationship with another service user, and the breakdown in her support network, namely difficult dynamics within the relationships between Ms C and her parents. We did not find any care plans which addressed this aspect of her care plan and the only reference was in the May 2016 care plan where she stated that she *"had no unmet needs in this area*". It should have also been apparent, and documented, that she found D's mental health fluctuations (and associated behaviours) stressful while they were cohabiting.

4.54 We believe this was a relevant social stressor, and that it should have indicated an increased risk of relapse when he was admitted to hospital in October 2018.

4.55 Ms C had a long-established diagnosis of a severe and enduring mental illness and BPAD but she consistently demonstrated poor insight into her diagnosis. She had not received any psychological input or psychoeducation into her illness and treatment plan at the point of discharge from services. There was no reference to this unmet need within her care documentation. It is our view that Ms C's care plan did not contain sufficient information to meet NICE guidance.

4.56 We have reviewed her care reflected against the relevant NICE clinical guideline below:

- Adults with bipolar disorder have their early warning symptoms and triggers of relapse, preferred response during relapse and personal recovery goals specified in their care plan.

- Carers of adults with bipolar disorder are involved in care planning, decision-making and information sharing about the person as agreed in the care plan.

4.57 Ms C was not offered psychological interventions as part of her care plan despite NICE guidance advising that: 'Adults with bipolar disorder are offered psychological interventions.'

4.58 Also, there were no carers identified within any of Ms C's care plans despite her living with D, who was supporting her with recovery but was also a known mental health service user himself. The relationship appears to have been fluid and often unstable.

4.59 Ms C did attend her GP for annual physical health checks in keeping with NICE guidance and was supported to attend these appointments by CCO3.

Findings 1.

The care plans that were in place for Ms C in the community were not reviewed in a meaningful way, with few interventions adjusted or implemented as changes in her needs occurred. Ms C's care plan was in date at the time of the homicide, in keeping with local policy for annual review.

Ms C's discharge from mental health services and removal of Section 117 entitlemer on 18 November 2015 complied with the CPA Procedural Guidance. However, we found conflicting guidance within the CPA Policy and CMHT Operational Guidance about when discharge from mental health services is indicated.

The interventions identified and provided to Ms C were not in keeping with NICE 'Bipolar disorder: assessment and management' Clinical Guidelines (2016). Ms C's psychological needs were not considered as part of her care needs and, subsequently, she was not offered intervention from psychological therapies or services to promote her recovery, as this guidance suggests.

We could not find any evidence to indicate that either Ms C or her partner, D, were offered a carers assessment.

We note that recommendation 3 from the internal investigation required independent carer assessments to be considered for each individual to help generate support plans. Our review of the implementation of this recommendation has confirmed that carer assessments are now available and offered to carers.

Forensic history known to the Trust's services

4.60 This table sets out the information held in Trust clinical records of Ms C's known incidents of violence and aggression.

Date	Offence
Goole Community Mental Health Services	
1993	Ms C repeatedly stabbed her two-year-old son causing serious wounding. The Crown Prosecution Service deemed that although there was sufficient evidence for the institution of criminal proceedings, there was also evidence that Ms C was suffering from a mental disorder. She was admitted to hospital under Section 3 MHA for treatment.
2010	There had been an altercation between Ms C and her mother. Ms C assaulted her husband and was admitted to hospital. Throughout the admission, there was evidence of aggressive behaviour
2010	Ms C punched her husband and tried to bite the police when they were called to intervene.
2012	Ms C caused damage to the family property and was also physically aggressive to her husband. She was observed to have suffered a manic relapse and was admitted to hospital under Section 3 MHA.
2012	Aggressive towards her mother.
2013	Ms C had demonstrated hostile and aggressive behaviour towards her husband and symptoms consistent with mania. Ms C was admitted to hospital.
2013	Police called to assist with assessment.
2014	Ms C was seen throwing property out of the front window of a friend's house causing significant damage. She also assaulted her friend by hitting her on the head with a bottle. The police were called and, armed with shields and using Tasers, they arrested Ms C. Ms C was experiencing a manic relapse with psychotic symptoms and was admitted to PICU under the MHA. Ms C also reportedly spat at police officers and needed to be restrained due to her violent behaviour.

2014	Ms C was found in a stranger's house having entered a bedroom placing a necklace around a child's neck. The police were contacted, and It was documented in her notes that she assaulted three police officers and spat at them. The police officers needed to use Tasers to manage her violent behaviour. Ms C had relapsed in mental state and was admitted to the PICU under Section 2 of the MHA. Throughout her admission, Ms C's behaviour was described as unpredictable and there were prolonged periods of verbal aggression towards staff and other patients.
2014	Secluded in hospital
Hull Community Mental Health Services	
2015	Ms C had a neighbourhood nuisance team involved in her care. The team considered her as a risk towards others due to physical confrontations/ altercations and they had previously received complaints from Ms C's neighbours. The team raised concerns in the context of domestic violence after observing scratches to Ms C's husband's face but records state he would not discuss this with the team.
2016	Ms C attempted to run over a police officer with her car. She later barricaded herself in the vehicle and assaulted three police officers when they tried to arrest her. She was suffering a further relapse in her mental disorder and was admitted to hospital for treatment.

Risk Assessment and Risk Management

4.61 The National Confidential Inquiry into Suicide and Safety in Mental Health guidance 'The assessment of clinical risk in mental health services' suggests that a good risk assessment combines 'consideration of psychological (e.g. current mental health) and social factors (e.g. relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people'[31].

4.62 A comprehensive risk assessment will take into consideration the patient's needs, history, social and psychological factors, and any negative behaviours (e.g. drug use).

4.63 The Royal College of Psychiatrists[32] recommends risk assessment should:

'…be part of, based on, and integrated within a thorough clinical assessment… [and] focus on risk formulation as part of a broader care plan. A risk-management plan should form an integral part of an overall treatment plan and not be separate from it.'

[31] The assessment of clinical risk in mental health services. National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH). Manchester: University of Manchester, 2018. https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf

[32] *Royal College of Psychiatrists "Assessment and management of risk to others" 2016* https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/managing-and-assessing-risk/assessmentandmanagementrisktoothers.pdf?sfvrsn=a614e4f9_2

4.64 In 2009, The Department of Health[33] identified 16 best practice points for effective risk management which include:

'The risk management plan should include a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions be taken by practitioners and the service user in response to crisis'.

4.65 Best practice in managing risk is based upon clinical information and structured clinical judgement. It involves the practitioner making a judgement about risk based on combining:

- an assessment of clearly defined factors derived from research (historical risk factors);
- clinical experience and knowledge of the service user including any carer's experience; and
- the service user's own view of their experience.

4.66 The Trust's Clinical Risk Assessment, Management and Training Policy (approved July 2018) includes reference to the minimum requirements for completion of risk assessments and risk management plans including the required frequency of risk assessments and reviews, training and education around risk assessment.

4.67 The Policy advises that risk assessments and reviews should be performed:

- at the initial assessment of the service user;
- prior to the CPA meeting;
- at any other key stages such as crisis or change in presentation or need; and
- at any other time judged clinically appropriate.

4.68 The Policy identifies which risks should be considered as part of the risk assessment and instructs staff to "consider the full range of risks in the context of the service users environment and circumstances (social, family and welfare circumstances)…including social inclusion and mental health promotion' such as:

- risk to self, such as self-harm, self-neglect, and vulnerability from others;
- risk to others, violence to others and risk to children; and
- other potential risk and risk factors including risk of abuse, exploitation, the effects of homelessness, isolation, social exclusion; risks associated with

[33] Dept of Health. "Best Practice in Managing Risk: Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services" 2009 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

particular physical health interventions; and risk pertaining to medicines, prescribed or self-administered.

4.69 The risk management plan should include:

- a summary of all identified risks;
- formulations of the situation in which identified risks may occur;
- how these risks will be managed;
- how the service user's strengths contribute to the management of risk;
- how the service user's strengths will be promoted through the development of important life skills e.g. problem-solving, stress management;
- how unhelpful or maladaptive behaviours will be reduced;
- each aspect of the plan allocated to an identified person, profession, or team;
- an identified lead clinician (e.g. CCO or case manager) who will; work with the service user to improve effective risk management, ensure the plan is recorded and communicated and ensure the plan is appropriately reviewed and updated;
- any known triggers of an increase in risk to self and others;
- any known signals or indicators of an increase in risk to self or others;
- awareness of the potential for service user's disengagement with care and whether that might signal an increase to risk to others or self;
- actions to be taken by the service user (or carer as appropriate) and by clinician in response to crisis;
- a date for review; and
- guidance on the reasons for earlier review.

4.70 The Trust utilises FACE[34] or START[35] as risk assessment tools. Specialist services such as forensic mental health services based within the Specialist Care Group employ the use of the 'HCR-20 Assessing Risk for Violence: Version 3' and the START tool, and those staff working within forensic services are provided with training of how to use these tools specifically.

[34] Functional Analysis of Care Environments (Clifford et al, 2012).

[35] The Short-term Assessment of Risk and Treatability

How Ms C's risk assessment was undertaken, her risk assessment and risk management plan

4.71 At the time of the homicide in October 2018, Ms C's risk assessment and crisis plan had last been completed on 26 July 2016, despite policy stating that this should be completed annually. We were not provided with a specific reason as to why this had not been completed since that date, but were advised that the service was incredibly busy, fast paced and struggled in respect of staffing resources. We have not been provided with evidence to support whether this was the case. As identified within the local report and at the point of interview, CCO3 continued to use this 2016 risk assessment and management plan to inform his practice and understanding of Ms C's risk. CCO3 said he reviewed risk at each contact with Ms C and recorded this within her electronic clinical care records but without population of a risk assessment tool or change to the risk management plan. We did see reference to risk within Ms C's electronic care records which was frequently just a comment such as "no current concerns regarding risk or relapse". We comment further on risk assessment below.

4.72 The risk assessment template populated on 26 July 2016 was titled 'Mental Health Services Relapse and Risk Management Plan' and included the following information:

- A summary of her current situation at that time. This included the recent changes that had been made to her medication in response to the side effects she had experienced whilst prescribed an antipsychotic medication.

- A summary of her last discharge which was precipitated by a manic episode with psychotic symptoms in respect of her primary diagnosis of BPAD. In this section of the risk assessment, Ms C was being supported by D who was now living with her and managing some practical tasks of daily living.

- Target signs, symptoms, behaviour suggestive of possible risk/relapse and potential triggers to relapse. At times of relapse, Ms C presented with pressure of speech, flight of ideas and a marked increase in grandiosity. Additionally, that Ms C's level of aggression may further increase if presenting as if in an elated phase. Triggers to relapse included an accumulation of stressful life events particularly if she stopped taking her medication.

- Actions to be taken by CCO3 in the event of relapse/risk were to increase face to face contact, ensure Ms C discusses her symptoms, provide effective coping strategies for coping with her low mood and ensure compliance with medication. Also, to review her risk assessment with consideration of an urgent appointment with her RC and referral to the Crisis Resolution Team or for an assessment under the MHA.

- Negative coping strategies were identified as isolation, disengagement from services and noncompliance with treatment plan.

- Help to avoid relapse: compliance with medication and engaging with allocated workers.

- Action to be taken by the service user in the event of relapse: Ms C was advised to contact CCO3 within typical working hours, and to liaise with a community mental health team duty worker in their absence. Out of hours advice for Ms C was to contact the CRT by phone or attend the Emergency Department to be assessed by the A&E Psychiatric Liaison Team.

- Action to be taken by the GP in the event of a relapse/risk: To contact Ms C's care team (either CCO3 or Consultant Psychiatrist) or to contact the CRT or Emergency Duty Team if action was needed out of working hours.

- Actions to be taken in the event of failed contact/noncompliance: CC03 was directed to contact Ms C by phone and to carry out an unplanned visit (a 'cold call') if there was no response after a considerable amount of time trying to make contact without success.

4.73 Ms C's last clinical care record entry on 14 October 2018, seven days prior to the homicide on 21 October 2018, indicated that there were no changes in respect to her risk assessment and no changes were made to her risk management plan.

4.74 CCO3 was responsible for completing the risk assessment tool for Ms C. Ms C's RC advised the investigation team that although he did not populate a risk assessment tool, risk was considered at each outpatient appointment (which CCO3 attended). Ms C was seen by her RC for outpatient appointments on three occasions; 16 August 2016 for a CTO review, 17 October 2016, and 6 February 2017 when the CTO was rescinded. Clinical risk was discussed at each appointment, the second containing less detail but included 'no significant risk'.

4.75 In keeping with the 'New Ways of Working Model', Ms C's medical reviews were arranged on a 'needs basis' on request by CCO3 when considered clinically indicated. At interview we were told that there would be opportunistic meetings where Ms C's RC and CCO3 could have a case discussion, and where CCO3 could raise concerns about Ms C's mental state and/or request a medical review.

Quality of risk assessment

4.76 Ms C's risk assessment template did not include an update to her current situation and potential risks at the time. The risk assessment did not fully include or consider her static and dynamic risk factors as instructed within the Clinical Risk Assessment, Management and Training Policy. There is no mention of the planned discharge from services. We would have expected to see up to date information in respect of:

<u>Living situation/relationship with D</u>.

4.77 Ms C was living with her partner D at her property but had indicated she wanted him to be housed separately. Ms C had reported living with D was affecting her mental health.

4.78 There were no interventions planned to reduce any potential risk associated with her living situation. Furthermore, in the days leading up to the homicide and following D's admission to hospital there was no update to her risk assessment. There was no evidence to support consideration of the potential risk of relapse should D be discharged or prescribed leave back to her home address, or any mitigating factors to reduce or manage this risk.

An investigation into benefit claims

4.79 Ms C was subject to an investigation into fraudulent benefit claims in respect of her living with her partner D and claiming that they lived separately.

4.80 Although CCO3 had evidenced that he was supporting Ms C in this respect, there was no exploration within her risk assessment about how this stressor may have affected her mental state and risks associated with this.

Chronic pain

4.81 Ms C had been experiencing chronic pain in her foot and ankle following the fracture she experienced when attempting to abscond from an inpatient stay. Ms C had gained a lot of weight and was reported to be isolating herself due to the pain associated with mobility.

4.82 Despite a robust plan and support extended to Ms C to access the community, chronic pain was not considered in the context of risk assessment and potential for relapse.

Known risk of noncompliance with prescribed medications

4.83 Ms C had been discharged from mental health services and from her S117 aftercare entitlement on 13 November 2015 due to poor engagement. Ms C was admitted to hospital on 4 January 2016 under Section 2 MHA following an attempt to run over a police officer and required an admission to a PICU. Ms C's admission was attributed to noncompliance with her prescribed medication and a relapse in her mental state and primary diagnosis.

4.84 Within Ms C's clinical records, there was a wealth of evidence indicating that previous relapses in mental state and subsequent admissions were triggered largely by noncompliance with prescribed medications.

4.85 It is widely documented that Ms C's risk was primarily managed through monitoring of her Lithium blood levels. There was a shared care protocol between Ms C's RC and her GP in respect of her Lithium prescription. The shared care agreement provided a framework for the prescribing of Lithium by her GP and set the monitoring of Ms C's plasma Lithium levels.

4.86 We were told by CCO3 that he relied on Ms C's blood results as evidence of her compliance with medication and that he did not review her medication in other ways such as checking her prescription boxes on planned visits. However, when the police searched Ms C's property they discovered twenty partially taken or full medication boxes; these were 13 boxes of 400mg Lithium tablets and seven boxes of 200mg Lithium tablets (please see Appendix D). The dates of prescription on the boxes ranged from 24 October 2016 until 18 September 2018. This suggests the possibility that Ms C was not compliant with her prescribed medications throughout this period especially given her recorded history and stated attitudes to medication. We discuss this in detail within the medicines management section of this report.

4.87 CCO3 told us that Ms C did not demonstrate any risks of relapse at the time of the homicide. They were reassured that Ms C was compliant with her medication owing to her having three monthly Lithium bloods tests performed by her GP, and by completing a face to face assessment at her home address on 14 October 2018, seven days prior to the homicide.

4.88 Ms C's risk assessment identified that Ms C had a history of noncompliance with medications that resulted in rapid deterioration of her mental state and relapse. The risk management plan confirmed that Ms C was responsible for managing her risk of noncompliance and relapse by ensuring that she took her medication as prescribed and was to attend her GP's for planned Lithium plasma bloods to be performed. However, no other checks were put in place to ensure that she was taking her medication, such as checking the medication packets.

4.89 We would have expected to see more robust risk management interventions within the risk management plan for Ms C to reduce risks of noncompliance. Also to safeguard others against the risk of violence and aggression given her history of relapses and the risks she posed to herself and others when unwell. It was the view of the CCO3 that a request to see the medication boxes may have impacted on their therapeutic professional relationship and trust. CCO3 said he did not observe any evidence to suggest that Ms C was not compliant with her medication.There was a missed opportunity by CCO3 to work more closely with the GP, to ensure the timeliness of prescriptions collected by Ms C and to play a more proactive role in reviewing her medication in the community. CCO3 told us he was aware that he could link in with a CPN in relation to support around medication monitoring and compliance, but that he had not thought it was indicated given Ms C's Lithium results. Ms C's RC told us he would expect the review of her medication tablets "to be happening by the Care Coordinator". There is no evidence that this expectation was communicated to CCO3 and there is no guidance within the CMHT's Operational Guidance to guide staff who may not be a registered nurse or doctor on when this may be indicated.

Findings 2.

It is clear from the clinical records that there has been:

- the repeated finding or suspicion of noncompliance with medication;

- the knowledge that Ms C could quickly and dramatically relapse at such times;

- the knowledge that Ms C attributed negative subjectivity to her medication (tiredness, sluggishness); and

- the knowledge that Ms C absolutely disagreed that she had the diagnosis for which Lithium was prescribed (BPAD) and maintained she had another diagnosis instead (post-traumatic stress disorder, menstrual psychosis).

History of incidents of violence and aggression, forensic assessment and/or consultation with specialist services

4.90 Ms C had an extensive history of risky and violent behaviour, as indicated earlier in this report. Given the extent of Ms C's history of violence and aggression towards others when experiencing a relapse, we would have expected all known incidents of violence and aggression to have been included in her risk assessment documentation in keeping with the Clinical Risk Assessment, Management and Training Policy. This would have provided a more up to date understanding of the severity of the risk she posed towards others when unwell, including if there were any persons more likely to be at risk of aggression from Ms C at these times. For example, we acknowledge the Structured Care and Intervention Plan of 27 December 2017 referenced Ms C driving her car at the police officer. However we would have expected to see a more detailed reference to all of her violent incidents, even if in summary, and an acknowledgement of how quickly Ms C could deteriorate when relapsing.

4.91 Ms C was referred for a forensic psychiatric assessment in the early stages of her involvement with mental health services in 1996. However, this assessment was not actioned, and the records are unclear in respect to why this was not completed by the Forensic Consultant Psychiatrist she had been referred to. The clinical records did include that a re-referral could be made at a later date, but there was no follow up or re-referral throughout the remainder of her care pathway in mental health services.

4.92 We were informed by Ms C's care team that they did not consider Ms C required a referral for forensic assessment or for forensic specialist input, despite the Clinical Risk Assessment, Management and Training Policy advising that:

'The initial or subsequent assessment of the service user's clinical presentation may indicate a more detailed assessment of the service user's risk of violence or harm to others is required…

… Forensic Mental Health Services are based within the Specialist Care Group and employ the use of HCR-20 Assessing Risk of Violence… on completion of risk assessment and reviews the multi-disciplinary team may identify the need for specialist advice on the assessment of violence in service users across the Trust. Teams may approach Specialist Services for further assessment of complex cases in need of a further review'.

4.93 The team had assessed Ms C as suitable for discharge from mental health services between December 2017 and October 2018. They advised that there was no clinical evidence to indicate that there was a continuing risk of violence to others which would require a forensic opinion on management.

4.94 In respect of the known history of violence and aggression towards herself and others, we would have expected a further referral for a forensic psychiatric assessment or consultation to have been arranged to support the reliability and validity of Ms C's risk assessment and risk management plan. There were many opportunities to refer her for a forensic psychiatric assessment, but the most appropriate time may have been after she attempted to run over a policeman in Scarborough on 4 January 2016. Even if it was decided that a forensic psychiatric assessment was not indicated, it would have been appropriate at this point to document the decision making process.

4.95 However, we are aware that there is no forensic outreach service within Hull, and that referrals would therefore generally be considered by forensic psychiatrists for admission to secure care. This is because they are not specifically commissioned to provide an 'outreach and liaison' function.

Psychological formulation of risk

4.96 Ms C's last risk assessment tool completed before the homicide did not fully include a comprehensive formulation of risk. Therefore, her risk management plan did not include any psychologically informed interventions to promote recovery and reduce further episodes of relapse. The Trust's Clinical Risk Assessment, Management and Training Policy does not specifically include guidance pertaining to a psychological formulation of risk; however, it does guide staff to complete 'formulations of the situation in which identified risks may occur'.

4.97 Given Ms C's extensive history of noncompliance with her medication regime and risks associated with relapse, we would have expected to see greater exploration and consideration of any underpinning psychological causes for noncompliance within her risk assessment documentation and as part of her formulation.

4.98 There is significant evidence within Ms C's clinical care records that she lacked insight into her illness when unwell and also in periods of stability. The records include that Ms C believed that she was experiencing post-traumatic stress disorder symptoms that she attributed to abuse and relationship difficulties she experienced as a child. Additionally, there are references in the clinical records that Ms C and her former husband had sought a private opinion in respect of her diagnosis (with regard to matters related to the custody of her child) and she had considered her primary diagnosis should be described as a '*menstrual psychosis'*. In fact, the Professor of Psychiatry had determined (in 1996) that Ms C had an acute puerperal psychotic episode of a BPAD.

4.99 When we interviewed Ms C as part of the investigation, she reaffirmed her belief that she believed her primary diagnosis was in keeping with PTSD and not BPAD.

4.100 If Ms C's lack of insight had been identified as part of the psychological component of her risk formulation, it may have triggered professional curiosity about how this could impact on the likelihood of her future compliance with prescribed medication. This could have informed risk management interventions offered to Ms C in the context of reducing further relapses, namely psychoeducation to improve her insight.

4.101 We consider that that the lack of update to Ms C's risk assessment and risk management plan following her CTO being rescinded on the 6 February 2017, was a missed opportunity to inform her longer-term risk management plan.

4.102 Ms C's CTO documentation completed by her RC identified that psychoeducation would help to mitigate her risk of noncompliance and this would be delivered by her care team. This was not included in her risk management plan by CCO3 as a risk intervention. When explored at interview, it was reported that Ms C was not offered psychoeducation as she had presented as compliant with medication whilst under his care.

4.103 We consider that there would have been insufficient clinical evidence to consider that Ms C's chronic risk of noncompliance had reduced given the longevity of time that Ms C had been in receipt of mental health services, the frequency of relapses she experienced attributed to her noncompliance with medication, and the omission to provide psycho-education as an intervention to address her lack of insight into her illness.

Ongoing monitoring

4.104 Ms C's risk assessment and management plan should have been updated as part of her outpatient appointments and CPA reviews. This would have provided her care team with an opportunity to review the efficacy and validity of Ms C's risk management plan from a shared perspective. They would also have been able to consider whether Ms C would have benefitted from input from other services (e.g. psychology services for psychological formulation) as part of the risk assessment.

4.105 Ms C was seen three times by her RC and did not receive a further medical review after 6 February 2017 when her CTO was rescinded. She was not offered further outpatient appointments because, in keeping with the New Ways of Working Model approach, CCO3 did not consider she needed a medical review; therefore, an appointment was not scheduled. Had Ms C been seen more regularly by her RC, there would have been another opportunity for the review of the current risk assessment and risk management plan.

4.106 Trust CPA guidance and CMHT Operational Policy does not provide detailed guidance with regard to the scheduling of medical reviews prior to discharge. We would suggest that the policies are updated to clarify the factors to be considered when discharge from services has been requested.

4.107 There was no review of Ms C's risk assessment following her last visit with CCO3 before the homicide occurred. As discussed earlier in this section of the report, the known dynamic risk factors and stressors she was experiencing before the homicide should have instigated a full review of her risk assessment

documentation, in keeping with the Trust's Clinical Risk Assessment, Management and Training Policy.

Safeguarding

4.108 Ms C and D were involved in a domestic violence incident on 12 June 2016. The police report identified that Ms C had been the aggressor towards D. There were two other incidents of domestic violence between Ms C and D which were not included within her risk assessment and management plan.

4.109 No further risk assessments were arranged thereafter, and no consideration was given for the need to complete a referral to a Multi Agency Risk Assessment Conference (MARAC). This was also identified within the Trust's local serious incident investigation.

4.110 We agree with the internal investigation that there was insufficient safeguarding consideration given to both Ms C and D and this should have been included in her risk assessment and risk management plan in keeping with local safeguarding polices.

Findings 3.

Ms C's risk assessment and risk management plan was not reviewed in keeping wi the Trust's Clinical Risk Assessment, Management and Training Policy (approved July 2018). The Policy requires staff to update the risk assessment tool at set intervals such as annual CPA reviews and when there were perceived changes to risk.

There were missed opportunities for a detailed assessment of her risk of violence towards others. The Trust's Clinical Risk Assessment, Management and Training Policy advised that this could have been enabled by her care team who could have consulted with specialist forensic services to support the risk assessment process. Additionally, there was a missed opportunity for a referral to MARAC which would have provided another forum to explore any risk of violence and aggression toward others.

Community Treatment Order

4.111 A CTO is designed for service users who are detained under the MHA in order to facilitate supervised treatment in the community. CTOs have conditions designed to promote service users' mental health and reduce the risk of relapse including recall to treatment in the event of a service user becoming unwell in the community.

4.112 The MHA describes the criteria that must be fulfilled for a CTO to be instated as:

- 'the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;

- it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;

- subject to his being liable to be recalled…such treatment can be provided without his continuing to be detained in a hospital;

- it is necessary that the RC should be able to exercise the power under Section 17E(1)…to recall the patient to hospital; and

- appropriate medical treatment is available for him.'

4.113 The Hull Community Treatment Protocol (2017)[36] indicates that the criteria which must be fulfilled by the RC to initiate a CTO as:

- the RC must be satisfied that the patient requires medical treatment for mental disorder for their own health or safety or for the protection of others and that appropriate treatment is, or would be, available for the patient in the community;

- in making their decision the RC must assess what risk there would be of the patient's condition deteriorating after discharge, for example as a result of refusing or neglecting to receive treatment; and

- the RC must be satisfied that the risk of harm to self and others arising from the patient's disorder is sufficiently serious to justify the power to recall the patient for treatment should they deteriorate.

4.114 A CTO can initially be implemented for a maximum of six months, after which it must be reviewed. It can then be implemented for a further six months before being reviewed again, after which it can be reviewed every 12 months.

4.115 The Trust's Care Programme Approach and Non-CPA Policy and Procedural Guidance (2017) advises staff that:

'It is a statutory requirement under the Mental Health Act (1983) for a Community Treatment Order (CTO) to be reviewed and it is good practice to do this as part of the CPA process. It is considered best practice for CPA Reviews for people on Community Treatment Orders to be held every six months rather than annually'.

4.116 A service user can be discharged when they are assessed by an RC as no longer meeting the criteria for a CTO. Ms C was subject to a CTO on two occasions during her care under mental health services.

4.117 Ms C was under Goole mental health services when her first CTO commenced. Ms C's CTO was in place between 5 January 2011 until June 2011 (unknown date). The rationale for Ms C to be subject to a CTO and the requirements of the CTO were to ensure her engagement with services and compliance with her medication. The CTO indicated that Ms C would pose a high risk of violence and

[36] Hull Community Treatment Order Protocol Prot509 (2017)

aggression to others should she relapse in mental state, which her RC considered to be likely due to noncompliance with her medication.

4.118 Ms C was under Hull CMHT West when she commenced on the second CTO following her discharge from hospital on 12 March 2016. Her CTO was in place from 12 March 2016 until it was rescinded on 6 February 2017. For the purpose of this investigation, our key lines of enquiry consider the effectiveness of the second CTO and the decision to discontinue it in February 2017.

Application/implementation of CTO

4.119 The CTO was commenced on the 12 March 2016 at the point of Ms C's discharge from hospital back to reside in the community.

4.120 While in hospital discussions were held within the multidisciplinary team (MDT) on how best to manage Ms C's condition. These discussions identified that numerous admissions were a result of noncompliance with prescribed psychotropic medication. Consideration was given to the significant risk Ms C posed to herself and others when she experienced episodes of relapse. Ms C had been started on a depot type medication to improve compliance and therefore the decision was made to initiate her on a CTO when she was discharged to the community.

4.121 The reasoning the MDT provided for the implementation of the CTO fulfilled the CTO criteria in that Ms C had a:

- long standing serious mental illness;
- chronic history of relapses associated with poor insight; and,
- history of noncompliance with medications which resulted in relapses and increased risk of harm towards self and others.

4.122 Therefore, it was, 'necessary for her health or safety or for the protection of other persons that she should receive such treatment'.[37]

4.123 Also, Ms C had medical treatment available to her and at that time 'such treatment can be provided without her continuing to be detained in a hospital'.

4.124 The conditions of the CTO that Ms C was required to adhere to were:

- she should make herself available for regular reviews at the Waterloo Centre (the location of where her CMHT were based);
- she should make herself available for regular home visits or clinical reviews at the Waterloo Centre with CCO3 and/or by other members of the Hull CMHT West; and

[37] The Mental Health Act (1983) S17A(5)

- she should accept prescribed Lithium medication on a daily basis for mood stabilising properties.

4.125 We are of the opinion that Ms C met the criteria for CTO and that the decision to commence her on a CTO was reasonable and proportionate. Historically, when Ms C had relapsed, she needed a psychiatric admission to ensure she received medication to facilitate her recovery and manage her risks of violence and aggression towards others.

4.126 We agree that Ms C should have been managed under a CTO as the provision of medical treatment was appropriate, in the best interests of Ms C's physical health, safety and the protection of others, and in keeping with local policy.

4.127 The Hull Community Treatment Order Protocol (2017) describes that;

'It is important to maintain close contact with patients on a CTO to enable monitoring of their mental health. The type and scope of these arrangements will depend on the patient's individual needs and circumstances including cultural, disability, ethnic or gender needs'

4.128 Whilst subject to the CTO Ms C was regularly reviewed by CCO3 and reviewed via outpatients appointments. This demonstrated the effectiveness of the CTO in supporting engagement with services. This also aligns to the requirements under the MHA and the Trust's Care Programme Approach and Non-CPA Policy and Procedural Guidance which states:

'There is an expectation that all patients subject to Community Treatment Orders will be regularly reviewed at MDT meetings, which includes discussions around timescales for planned medical reviews'.

4.129 Ms C's CTO was reviewed by her care team and by a First-Tier Tribunal panel on 16 August 2016 and the decision was made for the CTO to be extended. The decision to extend her CTO included:

- Ms C was suffering from a mental disorder of a nature that warranted that she was liable to the conditions of the order.

- She was suffering from a mental disorder of a nature that made it appropriate for her to receive medical treatment and that this was necessary for her health, safety and protection of others.

- The treatment required could have been provided without Ms C continuing to be detained in hospital provided that she was liable to be recalled for medical treatment and the necessity that the RC would continue to be able to exercise the power of recall to hospital for Ms C.

4.130 The First-Tier Tribunal report completed by her RC on 1 September 2016 concluded that she had been largely compliant with the conditions of her CTO in respect of engagement with services. This review of her CTO was in keeping with statutory requirements under the MHA. However, we note that there were

occasions when Ms C had not attended planned appointments with her care team.

4.131 Throughout this period, Ms C's depot medication had been discontinued although she continued to be prescribed Lithium and the dose was in the process of being increased. There had been no improvements in respect of her insight into her mental illness, and the risk of future noncompliance with medication remained active. Our opinion is that Ms C continued to meet the criteria for a CTO and the decision that she remain under a CTO based on her presentation and care needs was fair and reasonable. There were no changes made to the conditions of her CTO at this stage as she was considered to be compliant with the conditions already in place.

Monitoring the conditions of Ms C's CTO

Engagement with her care team

4.132 As referenced earlier in this section, Ms C was required to engage with planned appointments with her care team and take her prescribed Lithium medication daily. The MHA (1983) and The Trust's Care Programme Approach and Non CPA Policy and Procedural Guidance (2017) advised that 'reviews for people on Community Treatment Orders were to be held every six months rather than annually'.

4.133 Ms C attended planned appointments with CCO3 and her RC and had been attending her GP's for the purpose of Lithium plasma level blood testing to demonstrate compliance as part of her CTO conditions. On occasions, CCO3 accompanied Ms C to the pharmacy and for her Lithium blood monitoring.

4.134 Throughout the duration of the CTO (12 March 2016 until 6 February 2017), Ms C was seen separately by CCO3 on thirteen occasions: 9 and 13 August 2016; 13 and 20 September 2016; 6, 17 and 28 October 2016; 10, 16 November and 28 November 2016; 14 December 2016; 6 and 20 January 2017.

4.135 Ms C was also seen by CCO3 on seven occasions at planned medical reviews (not including the last medical review where her CTO was rescinded on 6 February 2017): 4, 17 and 31 May 2016; 24 June 2016; 21 July 2017; 16 August 2017; 17 October 2017 (Ms C also saw CCO3 at a separate visit on the same day).

4.136 There are occasions throughout this period where Ms C did not attend visits with CCO3 or for planned medical reviews that were subsequently rescheduled. There had also been attempts by CCO3 to contact Ms C by telephone without success.

4.137 Ms C had largely demonstrated compliance with the conditions stipulated with her CTO. Therefore, the CTO could be considered as effective in supporting Ms C to engage with services and comply with her medication prescription. This reduced the likelihood of relapse and risks she posed to herself and others when experiencing a relapse.

The monitoring of Ms C's medication compliance

4.138 Ms C's compliance with her medication was monitored via three monthly blood tests for her Lithium plasma levels. These were completed by her GP as part of a shared care protocol.

4.139 However, the sole use of Lithium blood results to monitor compliance was insufficient given her long standing history of noncompliance. The British National Formularly, states that:

> Plasma levels above 0 may indicate erratic compliance, full compliance or even long-standing noncompliance disguised by recent taking of prescribed doses.

4.140 Only four out of seven of Ms C's plasma results in this period could have been considered as therapeutic (0.6 to 0.8). Therapeutic plasma levels were recorded as; 13 March 2015 (0.7), 16 August 2016 (0.6), 6 October 2016 (0.8) and 1 December 2016 (0.6). Sub therapeutic levels were recoded as; 01 June 2016 (0.4), 20 June 2016 (0.3) and 11 July 2016 (0.4). In response to the sub therpeutic levels, we saw evidence that Ms C's bloods were taken at 3 weekly intervals, to make sure her plasma levels returned to a therapeutic level, which was achieved by August 2016. We note that the increase in monitoring Ms C's bloods throughout this period as evidence of good practice. More detail is provided in the Lithium levels table, Appendix E.

4.141 CCO3 did not request to review Lithium medications which had been dispensed such as medication boxes when visiting Ms C and the requirement for this was not included within the conditions of her CTO; however, her RC told us he thought that this was part of the monitoring of her medication compliance by CCO3 at visits with Ms C.

4.142 Ms C's CTO may have been effective in keeping her out of hospital as the conditions of the CTO included her requirement to engage with services, which she largely met.

4.143 However, the boxes of Lithium tablets that were found at Ms C's property after the homicide suggests the possibility that she could not have been taking her Lithium as prescribed (unless she was accessing or buying medication that was not prescribed by her GP). There is further exploration of this viewpoint in the medication section of the report.

Rescinding a CTO

4.144 The MHA advises that a service user can be discharged when they are assessed by an RC as no longer meeting the criteria for a CTO.

4.145 The MDT met on 6 February 2017 and the decision was made by her RC to rescind Ms C's CTO based on her compliance with medication over a 12-month period and that she had not required any psychiatric admissions during this time.

4.146 The decision to rescind the CTO was met and we consider that this was appropriate given her period of stability. Ms C had requested an admission to hospital on the 22 September 2017, but CCO3 did not think that this was

clinically indicated, rather was an attempt by Ms C to leave her temporary accommodation.

4.147 Ms C was last seen by her RC on 6 February 2017 when she was discharged from her CTO. Ms C did not receive a further medical review before the homicide on 21 October 2018.

4.148 We were told that Ms C was not scheduled for a planned medical review thereafter in keeping with the New Ways of Working model and that any medical reviews would be requested or arranged on a needs basis by the Care Coordinators directly (e.g. during a crisis or potential relapse). CCO3 did not request a medical review following rescinding of the CTO.

4.149 Although not included in policy, we would have expected for Ms C to be seen by her RC within twelve months given that she was prescribed Lithium, her risk history of relapse and as she was no longer subject to any conditions within a CTO framework to provide assurance about her stability in mental state.

4.150 The RC advised that the prioritisation of service users for medical reviews evolved with perceived clinical need. There were service user groups who received medical reviews at three monthly intervals or sooner e.g. those under the Ministry of Justice, with those subject to a CTO as the next set of patients for priority review.

4.151 When Ms C was subject to a CTO, she had planned and scheduled medical reviews. Her CTO status meant she received increased monitoring of her clinical need and risk.

4.152 The RC told us he did not think that rescinding Ms C's CTO had negatively impacted her opportunity for a medical review. He told us he had regular conversations with CCO3 about her clinical progress and/or risk informally, and/or when CCO3 raised issues of concern. We were given examples of when this happened, but these conversations were not documented in the clinical notes. We were told he assumed that CCO3 would document relevant parts of the conversation in Ms C's care record.

4.153 We were told that CCO3 did not think that a medical review was warranted. However, it is our view that Ms C's risk was not adequately assessed and this led to an assumption that she did not warrant a medical review.

4.154 There were missed opportunities by the community mental health team to review Ms C's risk as part of a multi-disciplinary team and via medical reviews. Best practice would mean that regular medical reviews were scheduled for Ms C following the discontinuation of the CTO given her previous history of relapse and associated risks towards others. This would have provided the team with assurances about her mental health and compliance with medication, instead of just relying on the GP blood tests for Lithium levels.

4.155 A further medical review may also have provided an opportunity for the RC to review the conditions under which the CTO was rescinded, and whether these had been implemented e.g. psychoeducation. This was recommended by the

First-tier Tribunal to mitigate against risks of future noncompliance with medication to reduce the risk of relapse and reduce the risk of violence towards others.

4.156 There is no guidance within the Service's CMHT Operational Guidance in respect of the role of the RC and when medical reviews should be arranged, their frequency and by whom.

Findings 4.

Ms C met the criteria for a CTO to be implemented and the review of this was in line with best practice and local policy. The planned medical reviews were also in keeping with the requirements of the local and national procedure for patients on a CTO.

The rationale for the renewal of Ms C's CTO on 16 August 2016 was proportionate and appropriate to meet her care needs and associated risks. The rationale for rescinding the CTO was similarly in keeping with the MHA requirements.

Ms C did not receive any planned medical reviews after her CTO was rescinded, and the MDT did not place adequate emphasis on her risk profile and manageme plan thereafter.

Medication

4.157 Ms C was initially commenced on Lithium medication in December 1996 whilst under the care of Goole mental health services. Over the course of her involvement with services, Ms C demonstrated a strong reluctance to take her medications.

4.158 Lithium is a long-term treatment for episodes of mania and depression. It is usually prescribed for at least six months. Lithium has a number of potentially serious side effects, and there must be a facility for regular blood tests to check that it is at a safe level, alongside kidney and thyroid function tests if the dose is increased. These regular blood tests may also be used to check whether there are therapeutic levels of Lithium in the blood.

4.159 When Ms C's care was transferred to Hull community mental health services, the Lithium prescription was continued as moderate release tablets, one gram (1g) to be taken at night, and she was also prescribed additional antipsychotic medication, Haloperidol 5mg, once per day. The table below outlines Ms C's medication prescriptions following her transfer of care on 27 April 2015 until the homicide occurred on 21 October 2018. The last change to her prescription before the homicide occurred was on the 12 September 2016.

Date	Medication
27 April 2015	Lithium Carbonate moderate release tablets 1g daily. Haloperidol tablets 5mg daily.
9 May 2015	Lithium Carbonate Moderate Release tablets 1g daily. Haloperidol tablets 10mg daily.

	Medication changes as an outcome to MHA assessment.
15 November 2015	Ms C was discharged from mental health services. Ms C had not been compliant with prescribed medications following her discharge from her last psychiatric admission on 26th January 2015.
12 March 2016	Discharged from inpatient admission and prescribed Zuclopenthixol Deaconate Injection 500mg every ten days.
4 May 2016	Zuclopenthixol Deaconate Injection 400mg every two weeks. Trihexyphenidyl Hydrochloride tablets 2mg twice daily. LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale)[38] assessment completed.
18 May 2016	Aripiprazole tablets 10mg daily. Lithium Carbonate slow release tablets 400mg daily. Zuclopenthixol Deaconate Injection 200mg every two weeks. Trihexyphenidyl Hydrochloride 2mg twice daily.
26 May 2016	Zuclopenthixol Decanoate Injection 200mg every two weeks, discontinued. Lithium Carbonate slow release tablets 400mg daily. Aripiprazole tablets, 10mg once daily for 14 days only.
31 May 2016	Aripiprazole Injection 400mg every 28 days. Aripiprazole tablets 20mg once daily. Lithium Carbonate slow release tablets 400mg daily.
6 June 2016	Oral Aripiprazole discontinued.
24 June 2016	Lithium Carbonate slow release tablets 600mg daily. Aripiprazole Injection 400mg every 28 days. No further reference to Aripiprazole tablets 20mg once daily.
16 August 2016	Aripiprazole Injection 400mg every 28 days discontinued. Lithium Carbonate slow release tablets 800mg daily.
12 September 2016	Lithium Carbonate slow release tablets 1g daily. There were no further medication changes before the homicide occurred on 21 October 2018.

4.160 Whilst Ms C was an inpatient in January 2016, she was commenced on Zuclopenthixol Decanoate 500mg, a long acting (depot) antipsychotic medication. It was initially prescribed as 500mg to be administered every 10 days. The Lithium was also maintained.

4.161 Ms C was prescribed a depot medication due to noncompliance with Lithium which precipitated this and previous admissions to mental health inpatient services. Ms C was placed on a CTO at the point of discharge from hospital (12 March 2016) and one of the conditions of this CTO was that Ms C was to be concordant with her prescribed medication.

4.162 On 3 May 2016, Ms C attended a medical review and these records indicated she had refused her last depot injection. Ms C had reported experiencing

[38] The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is self-rating scale for measuring the side-effect of antipsychotic medications. https://innovation.ox.ac.uk/outcome-measures/liverpool-university-neuroleptic-side-effect-rating-scale-lunsers/#:~:text=The%20Liverpool%20University%20Neuroleptic%20Side%20Effect%20Rating%20Scale%20(LUNSERS)%20is,side%2Deffect%20of%20antipsychotic%20medications.

unpleasant side effects to the depot. A LUNSERS assessment was completed by the Psychiatrist and significant side effects were noted. She was assessed as experiencing; 'sedation, tiredness, muscle stiffness, lack of emotions, slowing of movements and blurred vision…mild tremor was evident and very mild cogwheel rigidity was evident.' In order to reduce these side effects, the depot medication was reduced from 500mg to 400mg every two weeks. Ms C's RC also introduced Trihexyphenidyl[39] to reduce and manage these symptoms.

4.163 On 18 May 2016, Ms C's depot medication was changed from Zuclopenthixol Decanoate to Aripiprazole[40] initially as an injection and in tablet form, then the tablet form was stopped. The decision to change her antipsychotic medication was attributed to the EPSEs she was experiencing which were reported by Ms C and also observed by her care team.

4.164 The Trust 'Medicines Management Tool for Antipsychotics Policy' describes a pathway for assessment and intervention in cases of EPSE. A side effect checklist is advised, and a flowchart for assessment and prescribing. We have found evidence that this tool was used to assess her EPSE and to support decision making about prescribing only on this one occasion.

4.165 On 31 May 2016, Ms C requested that her prescription be changed to Lithium tablets only, as she wanted to discontinue medications that were administered by injection. Ms C's RC did not agree to this request and advised that in order for her medication to be changed to Lithium only, she would need to demonstrate a commitment to take her medication as prescribed and this would require a degree of trust to be established between herself and the care team in respect of this. Following this review, Ms C was prescribed Aripiprazole tablets 20mg daily, Lithium 400mg daily and she received her first depot injection of Aripiprazole 400mg to be administered every four weeks.

4.166 On 24 June 2016, Ms C's prescription of Lithium was increased from 400mg to 600mg daily and there was no further reference to a prescription of Aripiprazole tablets being prescribed thereafter. Ms C's prescription for her Aripiprazole depot was maintained at 400mg and administered every four weeks. The plan was for the antipsychotic medication to be reduced, with the aim to reduce side effects of the medication she continued to experience; *"the treatments are making me flat, I'm not happy, not interactive, I do not want to do things in the flat, I am sleeping all the time*".

4.167 The CTO was reviewed on 16 August 2016 and concerns remained that should Ms C be taken off the CTO, there would still be a risk of noncompliance with prescribed medication and she would therefore be at risk of relapse. The Lithium prescription was increased to 800mg per day.

4.168 Ms C was discharged from the CTO on 6 February 2017 after attending a medical review with the RC and CCO3. This was Ms C's last medical review prior

[39] https://www.evidence.nhs.uk/search?q=trihexyphenidyl. Trihexyphenidyl is part of a group of medicines called 'anticholinergic agents' that are used to treat symptoms such as tremor, shakiness and restlessness. Such symptoms may be caused by side effects of medication, particularly antipsychotics.

to the homicide in October 2018 and she was maintained on 1g of Lithium tablets per day. No changes were made to her medications thereafter.

4.169 National Pharmacological Guidance for the treatment of Bipolar Affective Disorder advises that:

- Lithium is effective in treating mania, recurrent depression, and preventing further mood episodes and suicide in adults with bipolar disorder;
- Lithium should be offered as a first-line, long-term pharmacological treatment for bipolar disorder;
- Lithium and antipsychotic medication are known to reduce the risk of relapse when used long-term in people with bipolar disorder;
- after the first year, plasma Lithium levels should be performed every six months, or every three months for people in any of the following groups… including people with poor adherence; and
- Lithium has a narrow optimum range, with plasma Lithium levels below 0.6 mmol per litre ineffective and plasma Lithium levels above 0.8 mmol per litre linked to increased toxicity. Once Lithium has been started and stabilised, plasma Lithium levels need to be maintained within the range of 0.6–0.8 mmol per litre.

4.170 Medication dose related guidance as outlined by the British National Formulary also states that adults should be prescribed, 'initially 1–1.5 g daily, dose adjusted according to serum-Lithium concentration, doses are initially divided throughout the day, but once daily administration is preferred when serum-Lithium concentration stabilised'.

4.171 Throughout her care episodes with Hull community mental health services, Ms C was prescribed Lithium therapy in keeping with first line treatment recommendations.

4.172 During Ms C's last psychiatric inpatient admission in 2016, she was commenced on a combination of antipsychotic medication and Lithium. Given Ms C's chronic history of noncompliance with prescribed medications, the decision made to commence Ms C on the combination therapy was proportionate in managing risk of relapse, promoting recovery and in keeping with NICE guidance.

4.173 The clinical records describe subjective and objective clinical evidence that Ms C experienced EPSEs associated with antipsychotic medication. The frequency, type and severity of these side effects can vary from person to person.

4.174 For Ms C, her side effects were described as 'significant parkinsonism'[41] and were to such a degree where she reported and was observed to continue to experience these after the discontinuation of her anti-psychotic medication.

[41] Drug-induced movement disorders include drug-induced parkinsonism (DIP), tardive dyskinesia (TD), tardive dystonia, akathisia, myoclonus, and tremor. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3325428/

These side effects can appear as a tremor/physical shaking and can be distressing and difficult for a person to experience and manage.

4.175 Furthermore, Ms C's RC considered that her side effects may have been early symptoms of her developing tardive dyskinesia.[42]

4.176 We observed a pro-active approach in the attempts made to reduce the severity of Ms C's side effects whilst maintaining a combination therapy. The dose of Zuclopenthixol Decanoate was initially reduced. Zuclopenthixol Decanoate is considered as a first-generation antipsychotic[43] and this was changed to Aripiprazole, known as a second-generation anti-psychotic.[44] There is some evidence that second generation antipsychotics have a different side effect profile.[45,46]

4.177 Ms C was prescribed Trihexyphenidyl, however, the 'Medicines Management Tool for Antipsychotics' advises that anticholinergic medication (such as Trihexyphenidyl) may exacerbate tardive dyskinesia. The tool suggests the use of three named medications, none of which were prescribed.

4.178 Ms C's side effects continued, and the decision was made to discontinue her prescription of anti-psychotic medication. This decision was intended to reduce the risks associated with continued use in respect of her physical health; however, the side effects scale should have been used more frequently as an objective measure of symptom reduction.

4.179 Ms C's GP was advised by her RC to review her blood plasma levels every three months in keeping with Hull and East Riding Prescribing Framework for Lithium in Affective Disorders and Cluster Headache[47] and NICE guidance[48]. These say:

- measure the person's Lithium levels every three months for the first year; and

- after the first year, measure plasma Lithium levels every six months or every three months for people in any of the following groups…people with poor adherence.

[42] Tardive dyskinesia (TD) is an uncommon but serious extrapyramidal side effect of antipsychotics. It can occur several months or even years after starting treatment and occasionally, when treatment is stopped.

[43] The first-generation antipsychotic drugs act predominantly by blocking dopamine D2 receptors in the brain. https://bnf.nice.org.uk/treatment-summary/psychoses-and-related-disorders.html

[44] The second-generation antipsychotic drugs (sometimes referred to as atypical antipsychotic drugs) act on a range of receptors in comparison to first-generation antipsychotic drugs and have more distinct clinical profiles, particularly with regard to side-effects. https://bnf.nice.org.uk/treatment-summary/psychoses-and-related-disorders.html

[45] Tarsy D, Lungu C, Baldessarini RJ. Epidemiology of tardive dyskinesia before and during the era of modern antipsychotic drugs. Handb Clin Neurol 2011; 100:601–16. http://dx.doi.org/10.1016/B978-0-444-52014-2.00043-4

[46] Miller DD, Eudicone JM, Pikalov A, Kim E. Comparative assessment of the incidence and severity of tardive dyskinesia in patients receiving aripiprazole or haloperidol for the treatment of schizophrenia: a post hoc analysis. J Clin Psychiatry 2007;68:1901–6. https://doi.org/10.4088/JCP.v68n1210

[47] Hull & East Riding Prescribing Committee Prescribing Framework for lithium in Affective Disorders and Cluster Headache (September 2012)

[48] NICE Clinical guideline [CG185] Bipolar disorder: assessment and management (2014).

4.180 Lithium has a narrow therapeutic index with a high potential for toxicity and therefore careful monitoring is required for safe use. Regular blood tests are important to ensure that the dosage is adjusted to be both safe and effective when changes occur.

4.181 The local 'Prescribing Framework for Lithium in Affective Disorders and Cluster Headache' provides guidance for the prescribing of Lithium by GPs and sets out the associated responsibilities of GPs and hospital specialists who enter into shared care arrangements.

4.182 A target serum-Lithium (plasma level) concentration of 0.8–1 mmol/litre is recommended for acute episodes of mania, and for patients who have previously relapsed or have sub-syndromal symptoms. However, a serum-Lithium concentration of 0.8–1 mmol/litre can also be indicative of Lithium toxicity. It is therefore important to determine the optimum range for each individual patient.

4.183 Routine serum-Lithium monitoring should be performed weekly after initiation and after each dose change until concentrations are stable, then every three months for the first year, and (normally) every six months thereafter. The monitoring of blood serum-Lithium level is intended to check for adverse reactions, as well as monitoring the therapeutic dose.

4.184 It is documented in Ms C's records that she was to have her Lithium levels checked by blood testing every three months. However, on review of the clinical records we noted that Ms C's tests for Lithium plasma levels were performed outside of these timeframes, which was surprising given her extensive history of poor compliance and the reliance placed on monitoring her compliance through her Lithium plasma levels (please see Lithium plasma results table in Appendix E). For example, there was:

- a six-month period between tests from March 2017 to September 2017;
- a four-month period between tests from September 2017 to January 2018; and,
- a six- and a half-month period between January 2018 and August 2018.

4.185 According to the records, Ms C's Lithium plasma levels were only taken twice in 2017 and twice in 2018. The clinical record for 18 August 2018 reports that Ms C's "mental health remains stable due to concordance with her treatment plan".

4.186 CCO3 supported Ms C to attend some planned GP appointments for her Lithium blood test to be performed. On these occaisions there was a missed opportunity for the time periods between testing to be discussed between her MDT and the GP in respect of any agreed shared care protocol arrangements for her Lithium prescription, and also to discuss monitoring Ms C's physical health whilst on Lithium.

4.187 Ms C's presentation and her Lithium plasma results may have indicated compliance with her prescription but additional measures or interventions to monitor compliance were not employed alongside this. We would have expected

a clear care plan, agreed with the GP, to monitor Ms C's compliance with her medication, including Lithium plasma results and checking her tablet use, particularly when her depot was discontinued.

4.188 Part of the clinical rationale for previously introducing the antipsychotic medication in an injection form was to increase Ms C's compliance with her treatment regime (based on her chronic history of noncompliance with prescribed medication). The known risks of this noncompliance were a relapse in mental state requiring admission and a known increase in violence and aggression towards others.

4.189 Lithium is only available in tablet form, and the change to oral medication alone should have been supported by a plan to monitor the potential risks of noncompliance. Lithium blood testing cannot solely be relied upon to evidence medication compliance, particularly in patients who have a history of noncompliance, although lower plasma levels may indicate incorrect titration of doses as well as poor compliance.

Findings 5.

Ms C's prescribed medication was in keeping with NICE guidance for the pharmacological treatments recommended for bipolar affective disorder.

The decision made to discontinue her prescription of antipsychotic medication (i.e. Aripiprazole) was reasonable and in Ms C's best physical health interests.

The plan to monitor Ms C's Lithium levels every three months was in keeping with the guidelines from the "Prescribing Framework for Lithium in Affective Disorders and Cluster Headaches"[49]. However, some testing of blood levels fell outside of these timelines.

Ms C has a complex and difficult history with episodes of disengagement but during this period she maintained contact with her care coordinator. We note that for much of 2018, apart from when she requested support with her partner, Ms C's presentation did not change or suggest that she was not taking her medication.

However, there was a missed opportunity for Lithium compliance to be assured aside from Ms C's Lithium plasma results and presentation at appointments with her care team. The Trust needs to ensure that increased monitoring arrangements are considered for patients with a long-standing history of noncompliance with prescribed medications.

The antipsychotic side effects monitoring tool was used on only one occasion in Ms C's care. This tool should be used more consistently to ensure the efficacy and validity of any changes made to medication to address unwanted side effects.

[49] Hull & East Riding Prescribing Committee "Prescribing Framework for Lithium in Affective Disorders and Cluster Headache", approved January 2015, reviewed March 2018

Mainstream community mental health services vs forensic community mental health services

4.190 Throughout Ms C's involvement with mental health services, she was predominantly under the care of mainstream community mental health and inpatient services; she was never under the care of forensic services. Mainstream community mental health services are typically for people with a diagnosed severe and enduring mental illness and may have a number of biological, psychological, or social care needs. Care is provided in keeping with the CPA.

4.191 People under CPA are allocated a care coordinator to manage their care. The role of the care coordinator is to lead on the assessment of a patient's care needs but they are additionally responsible for meeting any needs identified within the patient's care plan, either in person, or by signposting the patient to additional services. The role is to 'co-ordinate' a patient's care. Patients on CPA are also under the care of a named Consultant Psychiatrist.

4.192 Early in Ms C's contact with mental health services, she seriously assaulted her two-year-old son (July 1993). In respect of the offence, Ms C's case was directed to court and the presiding judge identified that Ms C was experiencing a mental health disorder and that she required medical treatment to be arranged by local mental health services. Ms C agreed to engage with mental health services and the presiding judge did not initiate any restricting frameworks at that time, such as a Section 37/41 MHA.

4.193 Ms C had a history of violence and aggression towards others (see section on risk assessment). The terms of reference for this independent investigation therefore extend to considering whether Ms C should have been referred to forensic services as a means of managing her care.

4.194 Humber Teaching NHS Foundation Trust provides medium and low secure (forensic) inpatient care for patients suffering from mental health disorders, learning disabilities and personality disorder. It offers assessment, treatment, and rehabilitation. Patients who are discharged from forensic inpatient services to the community are often referred to mainstream community mental to support recovery in the community.

4.195 A patient on a Section 37/41 MHA order who is under the care of a forensic CMHT or outreach service will be allocated a local authority social worker (a social supervisor) whose role is to report to the Ministry of Justice in respect of patient compliance with any restrictions identified within the conditional discharge.

4.196 At the time of Ms C's offence there were no commissioned forensic community mental health services. However, the Trust subsequently tendered for a forensic service, which has been in place since July 2020. Evidence provided by the CCG to us (see CCG section) shows that a discussion took place at an SI panel about the provision of forensic services whereby it was noted that the CCG is not the lead for the commissioning of forensic services.

4.197 As with mainstream community mental health services, the social supervisor may maintain the role of care coordinator, and visits are arranged in the community. Patients under the care of forensic CMHTs are also allocated a forensic consultant psychiatrist as their RC. The aim of these services is to manage and monitor patients' known forensic risk in the community and to promote recovery, with the overarching aim to discharge patients back to mainstream community mental health services.

4.198 Because there is no forensic CMHT/outreach service, we have not seen any referral criteria for such a service. However, there is a complex case care pathway, 'Managing Inpatient and Community Complex Cases for the Mental Health Care Group: A stepped approach to provide support to Inpatient and Community services'.[50] It is clear that Ms C would fall into this category of service users, but we have not seen any evidence that any consideration was given to applying this approach to her care.

4.199 There are usually a small number of service users who meet the criteria for forensic psychiatry, but we were told that it is difficult to be specific about the proportion of these as the community caseload changes frequently. At the time of our investigation staff said, "there may be five patients on the caseload for each team who at some time in their care may need to have a discussion with someone from a forensic service". We were also advised that the Clinical Lead for the service has oversight of those clients where forensic consultant expertise is required as they chair the community mental health services MDT meetings but, again, we have not seen any documentary evidence of this.

4.200 When asked about staff training for the identification of those service users who would benefit from forensic consultancy, we were informed that this is an "area of need and has been discussed for some time".

4.201 However, in relation to the monitoring of risk, Humber's CPA Policy and Clinical Risk Policy advises that it is the responsibility of the MDT to collaboratively assess and manage a patient's clinical risk. These policies advise that for mainstream services, a patient's risk should be assessed at least once a year as part of the CPA, and at times where there is potential for a change to risk e.g. crisis or new emerging risk factors. Staff in mainstream services are advised to use standardised risk tools such as the GRiST[51] or FACE to inform their risk assessments and subsequent management plans. Mandatory clinical risk training requirements for mainstream services is at least every three years. The clinical risk training package covers a variety of risks including some guidance on the assessment of risk of violence and aggression towards self and others.

4.202 The Trust's Clinical Risk Assessment, Management and Training Policy in place when Ms C was under the care of the Hull CMHT West advised services that 'initial or subsequent assessments of the service user's clinical presentation may

[50] Humber NHS Foundation Trust "Managing Inpatient and Community Complex Cases for the Mental Health Care Group: A stepped approach to provide support to Inpatient and Community services", May 2018.

[51] Galatean Risk and Safety Technology (GRiST) is a web-based application that reconnects us within a caring and supportive network using advice from thousands of mental-health experts. The goal is to reduce risks such as suicide and violence, improve wellbeing, and help us live safely in the community.

indicate that a more detailed assessment of the service user's risk of violence or harm to others is required'. The Policy also advised mainstream services that:

'Forensic Mental Health Services are based within the Specialist Care Group and employ the use of HCR-20 Assessing Risk of Violence… on completion of risk assessments and reviews the multi-disciplinary team may identify the need for specialist advice on the assessments of violence in service users across the Trust. Teams may approach Specialist Services for further assessment of complex cases in need of a further review'.

4.203 We note that a referral for a forensic psychiatry assessment in 1996 was never followed through. However, given the amount of time that had elapsed since then, it is extremely unlikely that Ms C would have remained on the caseload of a forensic service, if such a service had been available.

4.204 We do consider, however, that there was a further opportunity to consider whether a referral for a forensic psychiatry assessment would have been appropriate after the incident when Ms C drove at a police officer in Scarborough in January 2016.

Consideration of restriction order in 1993

4.205 The internal investigation report undertaken by the Trust could not identify any root cause. However, the report notes that:

'Given the serious nature of the incident displayed during this relapse and her well-established occurrences of previous dangerous behaviours, we asked our medical colleagues within the forensic service to review the report. This included a Consultant Psychiatrist and a Registrar who expressed concerns that the patient had been managed within mainstream mental health services and given her level of risk her should have been dealt with by way of court order as early as the assault on her own two year old child. Application of a Section 41 would have been more effective means of supervision than a Community Treatment Order'.

4.206 We do not consider that this had any real bearing on the homicide in 2018. There was a 25 year gap between the two events, during which a significant number of events occurred, all of which the Trust investigation should have taken into consideration in reaching its conclusion. These included:

- the break-up of Ms C's marriage;
- the commencement of a new relationship with another service user;
- repeat admissions to hospital;
- loss of income;
- moving home and area; and
- the breakdown of Ms C's relationship with her parents.

4.207 Any attempt to retrospectively posit a direct and robust causal association or link between two events 25 years apart (i.e. hospital disposal and homicide) is fraught with difficulties. These difficulties include the near impossibility of being able to accommodate, or control for, multiple potentially risk-relevant events or developments during the intervening time period (and as described above).

4.208 In addition, if Ms C had been placed on a supervision order by the courts in 1993, it is unlikely that she would still have been subject to these conditions in 2018, and the likelihood is that she would have been discharged from any forensic CMHT back to the care of mainstream services a long time before the homicide.

4.209 Furthermore, even if it is accepted for the sake of argument that a forensic admission could have reduced this specific risk, this scenario would require that Ms C had not only been placed on a restriction order in 1993, and admitted to forensic services, but also that she had then remained subject to conditional discharge and to supervision by forensic services until at least 2018. Home Office research from around this period confirms that many conditionally discharged patients people are quite quickly absolutely discharged (of a cohort of 370 people conditionally discharged between 1987 and 1990, 45% were no longer subject to restrictions when followed up as early as 1994). It would be highly unlikely for forensic services to follow somebody in the community for 25 years in the absence of further serious offending, and especially if they had been absolutely discharged. In other words, it is arguably highly likely that Ms C would have been absolutely discharged, and transferred back to adult services, well within a 25 year timescale.

4.210 In short, we would argue that although a Section 37/41 may have been entirely appropriate in 1993, it could not be seen to be so in 2018 without the significant benefit of hindsight. The comments by the forensic psychiatrists (above) has profound theoretical and practical problems, and we consider that this position cannot be robustly sustained. The report's conclusion also appears to be logically incompatible with the opinions and behaviour of the Trust's own clinicians; they did not consider or instigate a forensic referral at any point after 1996, they discharged Ms C from secondary care altogether in 2015, and they were preparing to do so again at the time of the incident.

Findings 6

In our view, Ms C's care was not negatively affected by her being under the care of a mainstream community mental health team as opposed to being under the care of forensic services, and it is most unlikely that she would have remained under forensic services from 1993 until 2018.

However, despite guidance within local policy, there was a missed opportunity to consider whether a more in-depth assessment of her risk of violence towards others was appropriate as late as January 2016. This could have been facilitated either by a Forensic Psychiatrist assessment or by consultation with specialist services in respect of her risk assessment and risk management.

5. Duty of Candour

5.1 The terms of reference do not require a detailed review of the Trust's internal investigation; however, we have commented on the findings of the report as they have arisen within our investigation.

5.2 We are required to review the Trust's application of the Duty of Candour, described below, and complete an assurance review of the implementation of the action plans developed afer the internal investigation (at section 7).

5.3 The Care Quality Commission (CQC) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 is a mandatory requirement that applies to registered persons when they are carrying on a regulated activity. The CQC says the regulation is intended 'to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong'.

5.4 Regulation 20 states that:

"1. Registered persons must act in an open and transparent way with relevant[52] persons in relation to care and treatment provided to service users in carrying on a regulated activity.
2. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must:
   a. notify the relevant person that the incident has occurred in accordance with paragraph (3); and
   b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification.
3. The notification to be given under paragraph (2)(a) must:
   a. be given in person by one or more representatives of the registered person;
   b. provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification;
   c. advise the relevant person what further enquiries into the incident the registered person believes are appropriate;
   d. include an apology; and
   e. be recorded in a written record which is kept securely by the registered person.
4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing:
   a. the information provided under paragraph (3)(b);

[52] 'A relevant person' under Regulation 20 does not include a victim's family and therefore under duty of candour regulations and GDPR there is no duty to provide a duty of candour letter to the victim's families.

b. details of any enquiries to be undertaken in accordance with paragraph (3)(c);
c. the results of any further enquiries into the incident; and
d. an apology."

5.5 The Trust told us it had been advised by the police not to contact any members of the victim's or Ms C's families because of the ongoing police investigation into the homicide.

5.6 The Trust consulted with a legal firm in respect of their obligation under Duty of Candour, who advised:

'…the Duty of Candour doesn't apply…the deceased was not a service user and Regulation 20(1) of the Health and Social Care Act…[the] provider must act in an open and transparent way with relevant persons...'

5.7 The Trust's Director of Nursing wrote to the victim's family on 12 February 2019, over three months after the homicide. She extended her condolences to the family and advised that the Trust was undertaking a serious incident investigation after which NHS England would commission an independent investigation.

5.8 The Trust advised that they were unable to write sooner to either the victim's or Ms C's families as they did not know who they were or have their contact details. We were informed that as soon as those details were provided to the Trust by the police, the Trust wrote to them promptly.

5.9 We are unaware of attempts by the Trust to speak with Ms C or her family in respect of Duty of Candour. However, CCO3 visited her after the homicide and the internal investigation team met with Ms C to share the investigation findings.

5.10 Although Duty of Candour requirements do not extend to the families of victims of mental health related homicides, we believe that Trusts have an ethical responsibility to establish contact with victim's families. In this instance, the Trust's actions to make contact with Susan's family were entirely in keeping with this duty.

5.11 Susan's family should have been given an opportunity to contribute to the terms of reference for the investigation. However, we note that the Trust was acting in accordance with the request from the police not to make contact, and that it sought legal advice to clarify its position.

Findings 7

The current Serious Incident Reporting and Management Policy indicates that where a homicide has occurred there must be communication with the families of victims ar perpetrators, and, close liaison should be undertaken with the police. However, as noted above, this did not happen because of the police request to not make contact.

6. Summary and recommendations

6.1 We have listed below the recommendations that we have developed through our analysis of the care and service delivery issues identified during this investigation.

6.2 It is clear that Ms C had a serious mental illness that was treated over many years by the Trust. She did not develop an understanding and acceptance of her mental illness, and this limited her cooperation with services. There was no evidence of psychological input to help her to develop this insight, nor was it tested to any degree. It was known that she had a history of becoming aggressive when mentally unwell, but her current risk assessments did not take this into consideration.

6.3 She continued to minimise the extent of her mental health issues, and did not want to take medication.

6.4 Ms C lived independently and had the ability to present as mentally well and in control of her life, when in fact she had made some choices which were not helpful to her. These were such as her new partner moving in with her, getting into difficulties with benefits claims, and not taking prescribed medication.

6.5 In the last year of her care, her needs were viewed as mainly social. There was an over reliance on Lithium plasma level results every three months as a means of monitoring her compliance with medication (despite this not happening), and there was a lack of recognition about the significant risk of violence and aggression that might arise from a relapse.

6.6 It became clear after the homicide that her risk assessment had not been updated in a timely way, and she had not in fact been taking her medication.

6.7 We have made the following six recommendations to improve practice.

Recommendations

Recommendation 1
The Trust should align the "Care Programme Approach (CPA) and Non CPA Policy and Procedural Guidance" and the "Operational Guidance, Hull Adult Community Mental Health Teams" so that staff are clear about the factors that must be taken into account when discharge from services has been requested or is being considered, and the operational protocols to be followed when discharge has been agreed, especially for those service users with a history of violence.

Recommendation 2
The Trust must assure itself that risk assessments and CPA documentation are kept up to date, and are of the appropriate quality, in line with Trust policies.

Recommendation 3
The Trust should consider, and reference in appropriate policies, the need for additional methods of monitoring compliance with Lithium to mitigate the risks of no concordance with treatment plans for patients with a history of noncompliance and who are at risk of relapse.

Recommendation 4
The Trust must update the "Operational Guidance, Hull Adult Community Mental Health Teams", to clarify the role of the Consultant Psychiatrist within the CMHT, and when a medical review of a service user's care should be sought. The Trust must assure itself that this revised guidance is being followed.

Recommendation 5
The Trust should seek to agree with the police how and when it can engage with families who have been affected by a mental health homicide.

We have also reviewed the implementation of the action plan following the internal Trust investigation. We have found some gaps in evidence that the actions have been completed and have made a residual recommendation about this.

Recommendation 6
The Trust should evaluate the evidence underpinning its action plan within three months to ensure it can demonstrate to the CCG that each action has been completed, tested and embedded. In instances where actions cannot be evidenced as closed, steps should be taken to fulfil the original commitments of the action plan within six months.[53]

[53] This is a residual recommendation pertaining to the Trust internal investigation action plan. We discuss this in section 7, 'Implementation of action plan'

7. Implementation of action plan

Summary assessment on progress

The Niche Investigation Assurance Framework

7.1 Assessing the success of learning and improvement is a nuanced process. The assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a numerical grading system to support the representation of 'progress data'. We avoid using traditional RAG ratings, instead preferring to help our clients focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained – with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation.

7.2 Our measurement criteria includes:

Score	Assessment category
0	Insufficient evidence to support action progress/action incomplete/not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded
5	Can demonstrate a sustained improvement

Assurance review of the Trust's action plan

7.3 The terms of reference for this review require an assessment of the implementation of recommendations which resulted from the Trust investigation into the care and treatment of Ms C. The terms of reference extend to the role of the CCG in implementing and monitoring the Trust's action plan.

7.4 The assurance review is to consider evidence provided by Humber Teaching NHS Foundation Trust and Hull CCG regarding the implementation and effectiveness of the internal recommendations. The assurance review will;

- assess and report on the progress made against the implementation and effectiveness of the recommendations from the internal investigation;

- consider if the recommendation related to the current commissioning arrangements for complex community patients provides sufficient assurance that staff have access to appropriate and timely input from forensic services including the advice, support and guidance required to deliver safe and effective care and treatment;

- identify any notable areas of good practice or any new developments in services as a result of the implementation of the recommendations; and

- consider any partially implemented recommendations and identify possible organisational barriers to full implementation providing remedial recommendations as appropriate."

7.5 The Trust internal investigation made seven recommendations predominantly focused on improving services at Hull CMHT West. The Trust provided an action plan that was approved and closed by the Clinical Risk Manager Group (CMRG) on 31 August 2019 (eight months after the homicide). All actions are recorded as complete. Whilst the action plan identifies action leads it does not record Executive Director sign off.

7.6 We spoke to the Assistant Director of Quality Governance and Patient Safety who explained the process by which Trust internal investigation reports and action plans are subject to review and sign off at the Quality and Patient Safety Group. This culminates in the report/action plan being signed off at executive level by either the Director of Nursing or the Medical Director. The Quality and Patient Safety Group has assumed the responsibilities of the CMRG in terms of signing off reports, though the CMRG is still responsible for monitoring the delivery of action plans.

7.7 The Trust did not provide a version of the action plan with embedded evidence but did provide a number of documents to underpin its findings. There are some gaps within the evidence, our assessment of which we set out below.

RECOMMENDATION 1:
Review of patients' risk and relapse plans to be incorporated into staff members clinical supervision agendas.

Action: A clinical supervision proforma to be developed for use within the Hull CMHT West service by all staff providing clinical supervision which will include a revise of Risk and Relapse plans/Face Risk Assessment to promote discussion of changes in circumstance and emergence of risk.

Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The Trust developed a new supervision proforma with a view to ensuring every supervision discussion includes documentation standards. • The Trust integrated Board report for June 2019 demonstrated 91% compliance for supervision against a target of 85%. • Trust Supervision Policy (clinical practice and non-clinical), July 2019	• The Trust individual supervision record is undated, though we note the supervision structure was reviewed in March 2019. • There is a section in the template called 'issues discussed' which lists areas including caseloads, CPAs, FACE Risk Assessments/Risk Plan and Safeguarding. • The audit sample size (n=ten) served as a 'snap shot' exercise providing

sets out staff supervision requirements. • West Hull Audit Report completed by the Interim Assistant Director of Nursing, Patient Safety and Quality Assurance, and the Clinical Lead of Hull CMHT West (26 July 2019). • The Audit Report set out its purpose in a number of areas including to establish whether Hull CMHT West were: "using the new clinical supervision proforma in practice which would provide assurance that discussions are held in each supervision session regarding: - documentation standards. - a review of risk and relapse plans. - a review of the FACE risk assessment." • The retrospective clinical record audit looked at ten patient records. • The Clinical Lead spoke to ten members of staff from different disciplines who confirmed the proforma was being used in supervision sessions. • Risk and Relapse Plans are no longer used by the Trust, rather the Care Plan includes a tab for a contingency plan. • The Trust audit looked at ten care plans, of which: – six had contingency plans for community based patients; – two had contingency plans specific for an inpatient setting; – one care plan did not have a contingency plan recorded; and	the Trust with some assurance though more frequent audits (e.g. quarterly) would provide further assurance. • Individual supervision records were not looked at during the audit due to staff confidentiality - therefore Trust evidence was anecdotal, relying on the Clinical Lead's own supervisory role. • The Clinical Lead's reliance on her own supervisory experience is a helpful indicator but impedes the audit independence. • The Audit Report is not underpinned by a supervision record review which would have validated verbal findings. • We have not seen evidence that the proforma is being used in supervision sessions, though note this would be difficult for the Trust to evidence without breaching staff confidentiality. • One of the Audit Report recommendations was for the Clinical Lead to work with team clinical supervisors to undertake a random audit of their supervisee's clinical records and support the implementation of any remedial action. We have not seen if this has been implemented.

– one case did not have a care plan as the patient was attending a 12-week group. • The Trust report concludes "… further work to be undertaken within the Hull CMHT West with regards to timely contemporaneous clinical record keeping to ensure the clinical record is complete and up to date at all times". • The Audit Report made six recommendations. • Standard Operating Procedure, Hull CMHT (July 2020). • Supervision Template Audit update, July 2020. Clinical staff (32) from West Hull CMHT asked to partake in audit. The response rate was 68%. Audit found of those who responded, 66% of staff were using the supervision template, 33% were not. The briefing concluded that though the majority of clinical staff were using the new clinical supervision template, there were still a number of staff who were not. The briefing set out four recommendations in response to the findings.	

NIAF rating: The Trust has implemented a new proforma and demonstrated it has taken steps to test its uptake. The Trust notes that further work is required to improve record keeping and we would suggest that further audit, staff engagement, and testing is required to embed practice.

Overall rating for this recommendation: 4

RECOMMENDATION 2:
Develop joint approaches between individual workers in teams who are working independently with patients who are partners, recognising carer stressors and discharge planning.

Action 1: Develop within the Family Inclusive Care Coordination Training workshop the need to consider the inclusion of partners who jointly access services to identify stressors particularly in plans to discharge into the care of each other and changes in clinical presentation and risk.

Action 2: To identify all patients who are partners and ensure the care plan reflects joint needs and communication.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Care Programme Approach (CPA) and Non CPA Policy and Procedural guidance (2018) includes reference to involving the patient's family. • The Family Inclusive Care Coordination training package (1 April 2019) has been modified to include partners who also access Trust services. This now says: "include partners who jointly access services to identify stressors particularly in plans to discharge into the care of each other and changes in clinical presentation and risk". • Ten clinical records were audited as part of the Hull CMHT West July 2019 record audit, of which none of the patients had a partner who was also a recipient of the CMHT services. • The Trust advised ensuring care plans reflect joint needs and communication has been discussed in supervision sessions. • The Trust told us that all patients are offered a carer's assessment, in keeping with Trust policy, which would identify if a carer was also a service user. In instances where it is identified that a patient has a partner who is also a service user, the respective care coordinators will establish the extent of joint working and family interventions acceptable to both partners. In instances where permission to share infromation is not given, there is an expectation that the care coordinators will maintain	• The Family Inclusive Care Coordination training pack does not provide further detail and/or give examples of carer stressors. • Beyond the audit sample, we have not seen evidence that the CMHT routinely tests whether any of its client base do have partners who are also recipients of CMHT services. However, the anonymised care records demonstrate the involvement of carers in the patient assessments. • The care records have a crisis plan section which record family contact details, views of the carer, contingency planning and relapse siganture. These were completed for the three anonymised patient records we were given. • There is no evidence of joint approach guidelines/policy for individual workers to refer to in instances where patients on their caseload have partners who are also recipients of CMHT services. • The new Individual Supervision Record does include a prompt to discuss patient families and/or carers, but we have seen no evidence that joint needs and communication have been discussed in supervision sessions.

regular contact to share information about potential risk and care planning, to identify factors which may help or hinder inteventions. • Carer contact details are to be added to the Care and Intervention Plan. • The carer is to be involved in care planning. • The Trust provided three anonymised care records completed in 2020. • Redacted discharge letter sent to the patient's GP (March 2020). The letter provides information pertaining to the patient's diagnosis, risk, management and medication, impression, Mental State Examination and agreed plan. • The Trust told us clinicians are supported to discuss strategies for intervention with colleagues in other teams. • MDT meeting notes for 08 July 2020 detail engagement with Trust support services. • Aide Memorie for CPA (undated) includes a prompt for caring for carers, including family, friends or signficant others. • The Trust told us it has developed a 'carers stress test' in response to Ms C's case. The Practice Note is entitled 'Identification of a carer in stres tool' and was sent to staff on 29 August 2019. The Practice Note directs staff to complete a 'The Relative Stress Scale Tool' when coming into contact with carers.	

• Details of staff attendance to 'Family Inclusive Care Co-ordination' training. • Adult CMHT Family Inclusive Training 2011 – 2020. Adult CMHT attendance (84), all adult CMHT attendance – on more than one course. (101).	
NIAF rating: The Trust has developed a family inclusion training package that highlights the need to consider partners who also use services. The Trust assessment documentation facilitates carer involvement, but we have seen limited information pertaining to instances where a carer is also a service user. We have also seen limited evidence of joint approaches being developed within teams to help staff mitigate and manage a situation like that of Ms C's if it were to arise again. **Overall rating for this recommendation: 2**	

RECOMMENDATION 3: Consider independent carer assessments for each individual to help generate support plans. **Action:** Remind all staff within the Hull CMHT regarding the need to offer, and support access to, a carer assessment and record and action accordingly for all service users on caseload.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Hull East CMHT Manager emailed CMHT staff (individual roles/teams not specified) on 28 March 2019 reminding them to offer and complete Carers Assessments in their clinical notes. Staff are directed to carer assessments on Lorenzo. The email asks three individuals (role not specified) to circulate to their respective teams. • The Clinical Lead spoke to 13 staff all of whom said they were aware of how to offer a carers assessment and how this would be progressed (West Hull Audit Report, July 2019).	• The Trust has provided evidence that carer assessments are available and offered to carers.

• West Hull Audit Report (July 2019) says carer assessments has been discussed in supervision sessions. • Ten clinical records were reviewed, all of which indicated a carers assessment had been offered, of which eight people declined and two had not confirmed whether they wished to have an assessment. • Clinical Audit Report – NICE Guidance (NG150) Supporting Adult Carers. Completed 17 June 2020.	
NIAF rating: The Trust has provided evidence that carer assessments are available and offered to carers. **Overall rating for this recommendation: 4**	

RECOMMENDATION 4: Recognising the increase in patients with a forensic history within Community Mental Health Teams, to work with the forensic services in the further development of peer consultancy and advice in the management of complex patients with a history of harm towards others. **Action:** Discuss with the commissioners the impact of increasing number of service users with complex forensic histories within CMHTs.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The Trust advised the issue of increasingly complex patients has been discussed at the Adult and Older Adult Delivery Group. • Part of the work being undertaken by the Delivery Group is to develop new models of care for CMHTs. • NHS England, Developing the 'Forensic Mental Health Community Service Model' Background Information Resource: (1 of 5) *The Data,* (2 of 5) *Service User Perspective,* (3 of 5) *Literature Review*, (4 of 5) *Core components of the model and the Specialist Community Forensic Team,* (5 of 5) *The Specialist Community Forensic*	• We have not been provided with evidence of these discussions having taken place. • We have not seen evidence of monitoring, or outcomes, from the Delivery Group. • We have seen no evidence that peer consultancy has been developed or enhanced access to forensic services for advice. • Evidence provided by the CCG to us (see CCG section) shows that a discussion took place at an SI panel about the provision of forensic services. It was noted that the CCG

Teams: values, knowledge and skills. • Terms of reference for Humber Coast and Vale Health and Care Partnership Mental Health Forensic pathways Specialist Community Forensic Team (SCFT), Clinical Governance Group. • Terms of reference for Humber Coast and Vale Health and Care Partnership Mental Health Forensic pathways SCFT, Pilot Wave 2 HTFT, Business meeting. • The Trust has successfully tendered for a Specialist Community Forensic Team. We were told this has been in place since July 2020.	was not the lead for commissioning forensic services. • We have seen limited evidence pertaining to the Trust's Specialist Community Forensic Team.
NIAF rating: The Trust has successfully tendered for a Specialist Community Forensic Team which serves to largely bypass the original recommendation. However, we have little information pertaining to this team or the nature of this service provision for complex patients with a history of harm towards others. **Overall rating for this recommendation: 3**	

RECOMMENDATION 5: All medical records need to be recorded on Lorenzo to help bring together the written coordination of a patient's care. **Action:** Contemporaneous electronic patient record (EPR) to be in place.	
Trust response and evidence submitted	**Niche comments and gaps in assurance**
• The Trust now has an electronic patient record (EPR) in place. • The Trust has secure Wi-Fi across its buildings facilitating secure remote access. • A West Hull Audit Report (July 2019) reviewed ten sets of clinical records, finding: o eight had a FACE risk assessment available on	• The West Hull Audit Report highlights gaps in record keeping based on a sample of ten clinical records. • There is evidence Lorenzo is being used, but not comprehensively. • The Trust action plan update says all communications are now sent electronically to GPs, though the Audit report identified one example of information not being sent to the GP. • The update indicates improvements in terms of IT availability (e.g. Wi-Fi)

Lorenzo (and therefore available to out of hours services); o one had a FACE risk assessment, care plan and CPA review completed; and o one patient's FACE risk assessment and care plan had not been updated since the patient's discharge from an inpatient unit in late 2018[54]. Ten records had care plans: ▪ one was out of date; ▪ one was completed on an inpatient unit in September 2018 and not updated to reflect community status; ▪ one patient attended a 12-week group and had no care plan; ▪ one CPA was not recorded on Lorenzo; ▪ one CPA not completed because of 12-week group; ▪ one set of notes had no correspondence to indicate the patient's GP has been informed of a change in the patient's legal status; and ▪ one record had not been updated to reflect recent contact. • The audit report concludes that further work is required to improve record keeping on Lorenzo. • The Clinical Lead for Hull West CMHT emailed CMHT staff on 27 December 2019 asking all supervisors to audit their supervisee's case notes in respect	and access but there is little to show this has improved record keeping. • The January 2020 audit findings are encouraging but relate to one member of staff. Further evidence is required to demonstrate broader improvement.

[54] The audit report says the FACE risk assessment was completed on 16.10.19, but we assume this was a typing error given the audit report was completed in July 2019 and should be recorded as 2018.

of defensible documentation standards. Guidance and an audit template were attached. • Example of Defensible documentation audit feedback. The feedback is undated, but the Trust advised it was completed in January 2020. All five of the reviewed care plans were in date and completed in line with NICE guidelines. No areas of learning were identified for the member of staff. • The Clinical Lead for Hull West CMHT emailed CMHT staff on 4 May 2020 reminding them she undertakes audits within Lorenzo and noting that the quality of CPAs was not in line with the Trust review process. The CPA Policy and a CPA Aide memoire were attached. • The Clinical Lead for Hull West CMHT sent an email to 34 CMHT staff on 22 May 2020 entitled 'Recording contacts on Lorenzo'. The purpose of the email was to remind staff to record all clinical activity on Lorenzo. Three documents were enclosed in the email: 'Contacts - 'creating a clinical note while recording a contact', 'Creating a Single Contact from Contacts', and 'Group Contacts – Actual Group Contacts from Caseload Management'. • CMHT compliance for information governance training was nearly 100% between 31 March 2020 and 30 June 2020 (compliance for one member of staff lapsed on 11 June 2020).	
NIAF rating: Medical records are recorded on Lorenzo, but the Trust has identified gaps in the quality of the record keeping which should be subject to further review, improvement and testing. **Overall rating for this recommendation: 3**	

RECOMMENDATION 6:
All staff to be reminded of their responsibilities regarding the sexual safety of patients in their care as per safeguarding policy.

Action 1: Staff training regarding sexual safety in Mental Health units to be available.

Action 2: A check needs to be made that staff are aware of their responsibilities under the Sexual Safety Policy.

Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Safeguarding Domestic Violence and Abuse Policy in place (2017). • The Trust provided the dates of Safeguarding development sessions that took place each month in 2018. The subject varied, though each session included a 15-minute safeguarding update/discussion. • A sexual safety task and finish group meets monthly. • Sexual safety task and finish group terms of reference (January 2019). • Extract of minutes from task and finish group (21/06/19, 18/07/19, 21/09/19 and 02/10/19). • Sexual safety training is embedded in Level 3 safeguarding training. • The Trust provides a safeguarding development session that focuses on 'Learning the lessons: domestic abuse". • All incidents are reviewed at the daily incident review meeting. • Sexual Safety Patient Leaflet and poster produced, impact of which to be tested in PICU three-month pilot. • The Trust Named Nurse of Safeguarding Children sent an email on 6 June 2019 to 'Safeguarding	• Trust Datix reports evidence action in response to sexual safety incidents. • We asked the Trust to provide further detail of the PICU pilot (e.g. outcomes). We were told the work has included the use of safety crosses at team level to identify potential sexual safety incidents and has improved accuracy and consistency in reporting. We were advised that the two units have been part of the national Sexual Safety Collaborative, this has been suspended due to the COVID-19 pandemic. It is anticipated the pilot will recommence in September 2020.

Humber' (it is not clear which staff were the recipient of the email) asking that Safeguarding training details be sent to all link staff/safeguarding supervisors in the Midday Mail. They highlighted domestic abuse training and provided a training calendar. • Team Safeguarding Children Level 3 training compliance was 85.7% on 30 September 2019. • Sexual Safety report, October 2019. • The Trust Deputy Director of Nursing advised that the daily corporate patient safety huddle reviews all incidents and escalates as required. A six-month review of all sexual safety incidents (Sexual Safety Report) was presented to the Quality and Patient Safety Committee in October 2019. A second report was scheduled to be submitted in March 2020 but has been delayed due to the COVID-19 pandemic. There is ongoing focus to ensure staff are identifying the right type of sexual safety incident – which has included a review of Datix categories – and ensuring the right level of harm is ascribed to incidents. • Sexual safety related incidents reported on Datix, all inpatient units, June-December 2019.	

NIAF rating: The Trust has provided evidence that safeguarding and sexual safety incident awareness is promoted, and training is available to staff, but further evidence is required to assess whether practice has become embedded and that staff are aware of their responsibilities under the Sexual Safety Policy.

Overall rating for this recommendation: 3

RECOMMENDATION 7:
The Trust Safeguarding Team to promote the appropriate responses to the issue of domestic violence and abuse across services.

Action 1: The previous five-minute focus regarding domestic abuse to be resent to all staff via midday mail, emailed to the safeguarding supervisors, link staff and managers to request dissemination and discussion is [sic] service areas.

Action 2: The Safeguarding Team will explore the possibility of all safeguarding link workers accessing the local safeguarding children partnership DASH training.

Action 3: The Safeguarding Team will ensure that the issue of domestic violence and abuse is discussed within forthcoming development sessions linking it to anonymised local cases.

Trust response and evidence submitted	**Niche comments and gaps in assurance**
• Domestic Abuse Champions poster (undated). • Safeguarding Domestic Violent and Abuse Policy (2017). • Five-minute focus sent to all staff via Trust midday mail on 7 June 2019. • The same email contained the safeguarding training diary for 2019 and highlighted the availability of domestic abuse training via Safeguarding Children Boards/Partnerships. • Safeguarding Team Five Minute Focus: Domestic abuse. The briefing provides a definition of domestic abuse, statistics, legal information and contact details for further information. The Trust told us the memo was sent to staff on 12 June 2018. • East Riding Safeguarding Children Partnership (ERSCO) multi-agency training programme 2019 details the availability of domestic violence training, DASH risk assessment training throughout the year. • The Trust advised domestic abuse has been discussed in development sessions in April and October 2018 and was to be delivered in July 2019.	• We have not seen the detail of the link worker review. • We have not seen the detail of the training sessions to be undertaken with the Hull Domestic Abuse Strategic Lead.

• Safeguarding Level 3 CMHT training figures as of 31 December 2019:
  o Safeguarding Adults, 75%
  o Safeguarding Children, 89.5%
• Virtual domestic abuse and DASH assessment training will be available from August 2020, co-facilitated by the Strategic Domestic Abuse Services Manager.
• The Trust told us the role of safeguarding link worker has been reviewed and stepped down with a request made for Domestic Abuse Champions across service areas instead.
• Safeguarding Supervisors continue to promote and support staff with domestic abuse concerns. The safeguarding role incorporates the sharing of safeguarding information and is responsible for providing members of their team with safeguarding training. The Safeguarding Supervisors have supervision training which is integrated into general supervision training.
• The Trust told us the Domestic Abuse Policy had recently been reviewed to reflect these changes.
• Safeguarding Domestic Violence and Abuse Policy (27 May 2020).
• Domestic Abuse awareness memo is published on the Trust intranet. The memo details the contact details for various domestic abuse support groups/outlets.
• Training sessions have been arranged with the Hull Domestic Abuse Strategic Lead.	

• Link to the DASH risk assessment tool on the Trust intranet. • Safeguarding Team Five Minute Focus: Domestic Abuse. The Trust advised this was communicated to staff by Mid-Day Mail. • Advanced Safeguarding Adults (V8 20 February 2020) training slides. • Safeguarding Adults case study – training material.	
NIAF rating: Domestic violence and safeguarding training is available to staff throughout the year, but we have not seen evidence of whether this has had a positive impact on the management and mitigation of domestic violence and sexual abuse. **Overall rating for this recommendation: 3**	

7.8 The Trust has provided evidence demonstrating progress with the action plan. The actions associated with four of the seven recommendations have been completed - but not tested - and in two cases (recommendations one and three), tested and embedded. Steps have been taken to improve patient records through supervision, proformas and staff training, and the Trust evidenced that carers assessments are offered to carers.

7.9 However, recommendation two was not evidenced to have progressed substantially and we do not consider the action plan as whole, is complete.

NHS Hull Clinical Commissioning Group

7.10 The NHS England Serious Incident Framework (2015) says that CCGs are responsible for ensuring the quality and robustness of an NHS provider serious incident investigation:

'… commissioners quality assure the robustness of their providers' serious incident investigations and the action plan implementation undertaken by their providers. Commissioners do this by evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of the serious incidents'.

7.11 CCGs can delegate this responsibility to Commissioning Support Units (CSU), but it is the CCG who holds overall accountability for investigation assurance.

7.12 CCGs have 20 days upon receipt of a provider investigation report to undertake a quality assurance review. The SIF includes a Closure Checklist which CCGs can use to facilitate their review and sign off a Trust report. The checklist is divided by investigation phase (e.g. set up, gathering and mapping information) and sets out

questions for the CCG to consider as part of their assessment e.g. 'Are good practice guidance and protocols referenced to determine what should have happened… is there evidence that the most fundamental issues/or root causes have been considered'.

7.13 Hull CCG and East Riding of Yorkshire CCG have terms of reference for their joint Serious Incident Panel. The terms of reference say each CCG is responsible for leading the review pertaining to their providers and that they must provide feedback and any additional requests for information, changes to the report or action plan. In instances when a mental health review is required for investigations which Hull CCG is responsible for, a bank mental health clinical reviewer will undertake a review on behalf of the CCG. The SI panel reports to the Directors of Quality and Governance/Executive Nurses for both CCGs, who in turn report to their Governing Bodies/appropriate committees. The SI Panel also reports to the Hull Quality and Performance Committee.

7.14 The remit of the SI panel includes:

'Review provider Serious Incident reports in line with the requirements of the NHS England Serious Incident Framework April 2015, and CCG serious incident policies to ensure an appropriate investigation has taken place utilising recognised root cause analysis methodology… monitor action plan implementation ensuring they are completed within set timescales'.

CCG review of Trust internal investigation report

7.15 The internal investigation report was originally due for submission on 18 January 2019, but the Trust requested an extension on 3 January 2019 because it was trying to contact the Consultant Psychiatrist associated with the case who had since left the Trust. The Trust submitted its report on the revised submission date of 8 February 2019.

7.16 The Trust investigation report was reviewed by a Registered Mental Health Nurse (RMN), specialist practitioner and the CCG SI panel on 27 February 2019. An 'assessment of Level 2 comprehensive serious incident investigation report and action plan' template/checklist was completed for the review. The template provides a column for provider responses to reviewer questions.

7.17 These questions, particularly in relation to Duty of Candour, were put to the Trust at the SI panel on 15 March 2019. The Trust sought legal advice in response to the review challenging the application of Duty of Candour, saying, "in relation to the family of the deceased, the Duty of Candour does not apply… there is no legal obligation arising therefore in relation to the family of the person who has been killed". The Trust added that following exchanges between the Trust and NHS England, letters were sent to the victim's husband and daughter.

7.18 The Trust did not provide responses to all the CCG questions. For example, no responses are documented in relation to:

'Has the organisation considered root cause in health care to be the first thing that could have happened or should have happened to prevent the incident from occurring?

Were all protective barriers in place to prevent harm from occurring?'

7.19 The overall assessment and feedback concluded for the report and action plan:

'Report accepted and required level of assurance provided, no/minor additional information required prior to closure'.

7.20 The CCG SI panel agreed to close the Trust investigation and monitor the action plan on 15 March 2019.

CCG review of Trust action plan

7.21 The CCG advised us that it will not close a Trust SI until evidence of implementation, ongoing monitoring, or completion of actions are provided to the SI panel. SIs are reported monthly and are a standing item at the Quality Group meetings which are chaired by the Executive Director of Quality.

7.22 The Trust submitted 16 documents to the CCG SI Panel as evidence that it had completed its action plan. The CCG provided a list of the documents which we consider to be the same as documents submitted to us by the Trust based on the document titles. The Trust did not submit evidence to the CCG in relation to actions four (forensic support) and five (use of Lorenzo). The minutes of the March 2019 SI panel indicate that a discussion did take place in relation to the provision of community forensic services, specifically that it was not currently commissioned by the CCGs.

7.23 The evidence provided to the CCG does provide partial assurance that the recommendations have been successfully implemented, but there are areas in which further evidence would have provided more robust assurance. For example, in relation to recommendation one, the Trust provided detail of the supervision passport and structure, but it does not detail whether all staff had received supervision. For recommendation seven, the Trust provided the CCG with dates for development sessions in 2018 and 2019 but the Trust could have provided detail of attendance to such sessions, at least for 2018. Equally we, note there has been little progress in relation to recommendation four.

7.24 The Trust evidence submission did not cover all aspects of the actions set out in the action plan. For example, for recommendation two, no further information is provided about developing the Family Inclusive Care Coordination Training workshop. For recommendation seven, DASH training is highlighted, but no further information given.

7.25 The CCG undertook a review of the Trust investigation in relation to adherence to the CCG SI Panel terms of reference. The Trust was given an opportunity to respond to questions and feedback about its investigation at the March 2019 SI panel, though not all CCG questions were answered; the reason for which were not documented. The Trust provided the CCG with a reasonable level of assurance in relation to implementing parts of its action plan, though there are areas in which further evidence should have been sought by the CCG to gain robust assurance and evidence of practice being embedded.

Appendix A – Terms of reference

Terms of Reference REVISED

Purpose of the review

To undertake an independent investigation into the care and treatment of Ms C ensuring that the investigations key lines of enquiry have been adequately considered and explored and highlighting any areas requiring further examination.

The original terms of reference allowed for the scope of the investigation to be widened following the outcome of the investigation's initial findings. The lead investigator raised some additional aspects that will require review. These covered aspects of care and treatment of the perpetrator raised by the affected family. The additional lines of enquiry are appended to the original terms of reference.

To conduct an assurance review of all recommendations within the Humber NHS FT internal investigation outlining if there is sufficient evidence to demonstrate implementation and effectiveness.

Involvement of the affected family members and the perpetrator

Ensure that all affected family members are informed of the review, the review process and are offered the opportunity to contribute to the process including developing the terms of reference; agree how updates on progress will be communicated including timescales and format.

Offer Ms C a minimum of two meetings, one to explain and contribute to the investigation process and the second to receive the report findings, subject to consultation with her RC.

Scope of the Investigation and Assurance Review

The investigation will consider the internal investigation commissioned by Humber NHS Foundation Trust.

The investigation will include:

- The sourcing and review of relevant documents to develop a comprehensive chronology of events by which to review the investigations findings against.
- Interviews with key personnel, where necessary, to provide additional supporting information.
- The review and assessment of compliance with local policies, national guidance including the application of the Duty of Candour and statutory obligations including safeguarding.
- Assessment of the care and treatment received by Ms C including the review of the adequacy of risk assessments, risk management and care planning including carers assessment. Identify any gaps or omissions in care not

adequately addressed within the investigation commissioned by Humber NHS Foundation Trust.

- Constructively review internal and inter-agency working and communication and identify any gaps and potential opportunities for improvement and make appropriate recommendations.

The assurance review is to consider evidence provided by Humber Teaching NHS Foundation Trust and Hull CCG regarding the implementation and effectiveness of the internal recommendations. The assurance review will:

- Assess and report on the progress made against the implementation and effectiveness of the recommendations from the internal investigation.

- Consider if the recommendation related to the current commissioning arrangements for complex community patients provides sufficient assurance that staff have access to appropriate and timely input from forensic services including the advice, support and guidance required to deliver safe and effective care and treatment.

- Identify any notable areas of good practice or any new developments in services as a result of the implementation of the recommendations.

- Consider any partially implemented recommendations and identify possible organisational barriers to full implementation providing remedial recommendations as appropriate.

Output

Provide a written report to NHS England that includes findings and measurable and sustainable recommendations for further action where necessary. The report should follow both the NHS England style and accessible information standards guide.

The lead investigator should highlight any areas that require additional investigation and raise these with the commissioner as the investigation progresses.

Provide a concise case summary to enable sharing of any wider learning.

Provide NHS England with a monthly update, template to be provided by NHS England, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

Support an action planning and/or learning event to promote learning opportunities for the provider.

Within six months of publication conduct a further assurance review on the implementation of any new or outstanding recommendations in conjunction with the CCG and Trust. Provide a brief written report outlining the outcome of the assurance review to NHS England, North. Terms of reference will be developed on receipt of any associated action plans.

Revision to Terms of Reference - additional Key Lines of Enquiry

There are four aspects that require additional consideration in light of the findings from the desktop review conducted by Niche Health and Social Care Consulting and from questions posed by the victim's family.

Community Treatment Order (CTO)

To consider the implementation and effectiveness of the CTO and the decision making to rescind given the remitting nature of her illness. Our considerations will include Ms C's previous history of poor medication compliance, her clinical presentation (and relapse risk profile) and the key factors that resulted in the CTO being rescinded.

Medication

To consider the medication prescription at the time of the homicide to understand the rationale for this, how Ms C's Lithium prescription was being managed against best practice guidance and how Ms C's medication compliance was being monitored and reviewed. We will also consider how risk issues in relation to noncompliance were recorded and managed.

Risk Assessment and Risk Management

To review the reason why Ms C's risk assessment was out of date at the time of the homicide although noting that risk information was documented within case records on the electronic record system. We will review the clinical care record to understand if all known risk information was included within. We will consider the proportionality of her risk management plan against this information, and in keeping with best practice. This will reflect on the known cyclical nature of her remitting illness and the serious risk she posed previously when she became unwell.

We will consider how any risk of relapse or known risks, associated with Ms C's relationship with another patient, was captured within Ms C's risk assessment and risk management. What if any consideration was given to her vulnerabilities as a service user herself?

Care provision at the time of the homicide

We will consider if the placement of Ms C within mainstream services as opposed to specialist forensic services had any bearing on the outcome of the homicide. Given Ms C's risk history, we will explore the suitability of her care provision at the time of the homicide taking into account the internal report findings that identified a missed opportunity for Ms C to be subject to a court order (Section 41, MHA 1983), following the initial assault of her son as opposed to a CTO being in situ.

Appendix B – Documents reviewed

Humber Teaching NHS Foundation Trust policies and other documents

Clinical Risk Assessment, Management, and Training Policy (N-015) 2018

Hull Community Treatment Protocol 2017

Suicide and Self Harm training package

Operational Guidance Hull Adult Community Mental Health Teams 2017

Information and standards to complement the competency workbook in medicines optimisation for registered, unregistered and student health practice

Care Programme Approach (CPA) and Non-CPA Policy Procedural Guidance (2017 and 2019)

Safeguarding Domestic Violence and Abuse Policy (2017)

Medicines Management Tool for Antipsychotics Policy

Family Inclusive Care Co-ordination teaching pack

Clinical Risk Training Package (no date)

Safeguarding Development Session. Learning the Lessons: Domestic Abuse (no date)

Managing Inpatient and Community Complex Cases for the Mental Health Care Group: A stepped approach to provide support to inpatient and community services

Other documents

Hull and East Riding Prescribing Committee Prescribing Framework for Lithium in Affective Disorders and Cluster Headache 2015 (reviewed March 2018)

NICE Patient Information Lithium Therapy sheet

The Maudsley Prescribing Guidelines in Psychiatry 2018

South West Yorkshire Partnership- Clinical Risk, Formulation and Management training pack

The Department of Health (DOH) CPA Framework 1991 (updated 2008)

Appendix C – Lithium information

Record of Lithium Prescription since stabilised on 1000mg Daily

Date	GP Prescribed	400	Taken	200	Taken		Serum Lithium
							01/06/2016 (0.4)
							21/06/2016 (0.3)
							11/07/2016 (0.4)
							06/09/2016 (0.6)
24/10/2016	56/30 (20/10)	56	6	25	0		06/10/2016 (0.8)
11/11/2016	56/30 (11/11)	56	2				
08/12/2016	56/30 (7/12)	56	0	30	10		01/12/2016 (0.6)
05/01/2017	0/30 (7/1)						
09/01/2017							
13/02/2017		56	26				
24/03/2017	56/0 (13/1)	56	0				15/03/17 (0.7)
21/04/2017	56/0 (20/4)						
03/06/2017	56/30 (2/6)			30	6		
26/08/2017	56/30 (25/8)	6	6			Emergency Supply	
30/08/2017	56/30 (15/7)	50	38	27	9		
02/10/2017	56/30 (18/9)	56	2	30	0		15/09/17 (0.9)
28/11/2017	56/30 (28/11)	56	0	30	0		
26/12/2017							
23/01/2018	56/30 (22/1)						26/01/2018 (0.6)
20/02/2018	56/30 (14/2)						
03/04/2018		56	0				
26/04/2018	56/30 (24/4)	56	0	30	0		
24/05/2018	56/30 (2/6)						
17/08/2018	56/30 (10/8)	56	0				07/08/2018 (0.8)
18/09/2018	56/30 (15/9)	56	0				
Excess Tablets		39		44			

Appendix D – Record of Lithium levels

Record of Lithium levels

	Date	Serum Lithium	Additional comment
	26/01/2015	0.7	
	19/02/2015		Hull GP now prescribing Lithium
	26/02/2015		Lithium level to be recorded every 6 months
CTO	13/03/2015	0.7	
CTO	01/06/2016	0.4	
CTO	20/06/2016	0.3	
CTO	24/06/2016		As Serum Lithium level borderline further bloods requested for 3 weeks' time
CTO	11/07/2016	0.4	
CTO	21/07/2016		Lithium tablets increased from 400mg to 600mg daily
CTO	16/08/2016		Lithium increased from 600mg to 800mg daily
CTO	06/09/2016	0.6	
CTO	12/09/2016		RC letter to GP – Advised to increase Lithium Carbonate to 1000mg nocte
CTO	14/09/2016		GP Record – Lithium 200mg modified-release tablets (Essential Pharma M) – 30 tablet – 1 to be taken Each Night Lithium 200mg modified-release tablets – 30 tablet – 1 to be taken Each Night
CTO	06/10/2016	0.8	
CTO	06/10/2016		Increased Lithium to 1g
CTO	01/12/2016	0.6	
	15/03/2017	0.7	
	15/09/2017	0.9	
	26/01/2018	0.6	
	07/08/2018	0.8	

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