An independent investigation into the care and treatment of Mr G

Extended executive summary

Sancus Solutions Ltd,
Unit 8B, Lockside Office Park,
Lockside Road,
Preston PR2 2YS
enquiries@sancussolutions.co.uk
www.sancussolutions.co.uk

Sancus Solutions wish to thank Mr G and members of the families of Mr G and his stepfather for their contribution to this investigation. It is hoped that this report does not contribute further to their pain and distress.

Sancus Solutions' investigation team would like to acknowledge the contribution and support of staff from Bradford District Care NHS Foundation Trust, Airedale NHS Foundation Trust, West Yorkshire Police and Silsden Medical Practice.

Contents

1 Introduction

NHS England and NHS Improvement (North East and Yorkshire) commissioned Sancus Solutions (hereafter referred to as the investigation team) to undertake an investigation into the death of Mr G's stepfather. This investigation was commissioned under Appendix 1 of the NHS England Serious Incident Framework.[1]

The overall purpose of the investigation was to:

"Undertake a review of care and treatment provided to the perpetrator by the NHS, the local authority and other relevant agencies, including compliance with local policies, national guidance and relevant statutory obligations.

Review the appropriateness of the care and treatment of the victim, leading up to the incident, in the light of any identified health and social care needs.

Identify any gaps, deficiencies or omissions in the care and treatment received by the perpetrator [Mr G] and the victim [Mr G's stepfather] which could have predicted[2] or prevented[3] the incident.

Establish what lessons can be learned from the domestic death regarding how professionals and organisations operate both individually and together to safeguard future victims.

Ensure that all affected families are informed of the investigation, the investigative process and understand how they can contribute; agree how updates on progress will be communicated. Offer a meeting to the perpetrator so that he can contribute to the investigation process."[4]

2 The incident

Mr G's mother called the police to report that her son had pushed her husband down the stairs and had stabbed him.

[1] The 2015 Serious Incident Framework set the expectations for when and how the NHS should investigate serious incidents. NHS Serious Incident

[2] Predictability: the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. Predictability

[3] Preventability – To prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring Preventability

[4] NHS England ToR p1 Members of the investigation team met with Mr G's mother on two occasions to discuss the purpose of the investigation and the ToR. Sancus Solutions' family liaison officer met with both Mr G and his step siblings and invited Mr G's sibling to be involved. At the time of writing this report, he had not responded.

Mr G subsequently pleaded guilty to the manslaughter of his stepfather on the grounds of diminished responsibility. He was detained under Section 37/41 of the Mental Health Act 1983[5] and placed in a medium secure hospital.

3 Mental health diagnosis

During Mr G's hospital admissions with Bradford District Care NHS Foundation Trust (hereafter referred to as BDCFT)[6], the following mental health diagnoses were being considered:

- 2015: bipolar affective disorder, manic episode without psychotic symptoms (International Classification of Diseases[7] diagnostic code F311) and adjustment disorder (International Classification of Diseases diagnostic code F432)
- 2017: mental and behavioural disorders due to multiple drug use (International Classification of Diseases diagnostic code F199).

4 Key events – 2017

- 7 February 2017: Police attended an incident involving Mr G and his stepfather. This resulted in the police utilising Section 136[8] of the Mental Health Act 1983 to escort Mr G to hospital. He was subsequently detained under Section 2 of the Mental Health Act 1983.[9]

- 16 February 2017: Mr G was transferred to Airedale NHS Foundation Trust's[10] acute medical ward, where he underwent treatment for staph aureus septicaemia[11] secondary to cellulitis[12], and multiple pressure sores.

[5] A court decided that instead of going to prison the offender should be in hospital for treatment of a serious mental health problem. A Section 37 is called a "hospital order". The judge decided that because of concerns about public safety, the offender also needed to be on a Section 41, which is known as a "restriction order". Before they make such an order, the court must be satisfied that it is necessary to do so to protect the public from serious harm. It means that a patient cannot be discharged from hospital unless by the Ministry of Justice or a tribunal. An appeal to the Mental Health Tribunal can be made once in the first 12 to 24 months after the conditional discharge and then once in every two-year period. Section 37/41

[6] BDCFT

[7] The International Classification of Diseases (ICD) is the international standard diagnostic tool for epidemiology, health management and clinical purposes. ICD

[8] Section 136 – Police can use this section if they assess that a person has a mental illness and requires 'care or control and to be taken to a place of safety such as a hospital, police station or someone else's home'. This section can only be used if the person is in a public place. Section 136

[9] Section 2 of the Mental Health Act 1983 – A patient can be detained in hospital for up to 28 days. This section gives doctors time to assess the type of mental disorder and treatment required. Section 2

[10] Airedale NHS Foundation Trust

[11] Staphylococcus aureus is a serious infection associated with high morbidity and mortality and often results in metastatic infections. Staphylococcus

[12] Cellulitis is a common, potentially serious bacterial skin infection. NICE guidelines

- While Mr G was on Airedale NHS Foundation Trust's acute inpatient ward, his Mental Health Act 1983 section was regraded to Section 3.[13]

- During this admission Mr G's presentation posed many challenges to his treatment. He often placed himself in high-risk situations which were further exacerbating his physical symptoms – for example, non-compliance with his medication, jumping off furniture, refusing to use the pressure-relieving mattress, and pulling out his cannula, through which his intravenous antibiotics and fluids were being administered.

- For the majority of the admission at Airedale NHS Foundation Trust's acute inpatient ward, BDCFT's inpatient unit's staff were providing 24-hour supervision of Mr G. It was documented that there was some confusion about the role of BDCFT's staff – for example, whether they were providing nursing care or were there just to observe Mr G.

- There were two occasions when Mr G was refusing to take his medication and BDCFT's staff documented that they had observed a family member covertly administering[14] his prescribed medication to him. These incidents were documented in Mr G's BDCFT patient records. Airedale NHS Foundation Trust's acute inpatient ward staff reported that they were unaware that these incidents had occurred.

- 21 March 2017: Mr G was transferred back to BDCFT's inpatient unit, where his mental and physical health began to improve, and on 20 April 2017 he was discharged.

- Once discharged there was a short period of involvement from the community mental health services under a before Mr G requested to be discharged. After Mr G's discharge, his mother was managing the ongoing treatment of his pressure sores.

- Mr G's discharge was managed under Care Programme Approach.[15]

- Following Mr G's discharge from hospital, his GP began to see him regularly both at the surgery and at his home. The GP documented that Mr G was experiencing ongoing and escalating mental health and behavioural issues.

- Mr G's mother attended these appointments and was also in regular telephone contact with the GP.

[13] Section 3 of the Mental Health Act 1983 – A patient can be detained in hospital for up to six months or longer for treatment. Section 3

[14] Covert administration is when medicines are administered in a disguised format without the knowledge or consent of the person receiving them. It was documented in BDCFT's patient records that Mr G's mother was observed hiding her son's medication in yoghurts.

[15] The Care Programme Approach (CPA) is a package of care for people with mental health problems CPA

- The GP sought advice from the community mental health service's consultant psychiatrist. Mr G was prescribed the antipsychotic medication olanzapine[16], and in August 2017, the antidepressant duloxetine[17] was also being prescribed.

- The GP last saw Mr G on 4 September 2017, when Mr G's mother reported that there had been an incident (2 September 2017) where her son had been violent and that she and her husband "had barricaded themselves in their bedroom"[18]. The police arrested Mr G, but he was subsequently released without charge.

Dispensing error

- During the course of the police investigation[19] into the death of Mr G's stepfather it was discovered that on 21 August 2017 there had been a dispensing error by the community pharmacist. Mr G had been dispensed the antidepressant mirtazapine[20] instead of the prescribed antipsychotic medication olanzapine.

The following section briefly documents Sancus Solutions' responses to NHS England and NHS Improvement (North East and Yorkshire)'s ToR.

5 Risk assessment and risk management

The ToR asked the investigation team to:

"Review and assess the risk assessments and risk management undertaken by all agencies, including the review of the risk of the perpetrator harming himself or others and determining compliance with local policies, national guidance and relevant statutory obligations.

Review how risk information was shared and escalated between the involved agencies to determine if this was appropriate, timely and effective."[21]

BDCFT

The investigation team reviewed Mr G's patient records from 2015 and 2017 and made the following observations:

[16] Olanzapine is an atypical antipsychotic primarily used to treat schizophrenia and bipolar disorder. Olanzapine
[17] Duloxetine is a type of antidepressant known as a serotonin-noradrenaline reuptake inhibitor (SNRI). Duloxetine
[18] West Yorkshire Police's IMR p21
[19] This dispensing error was reported during Mr G's trial
[20] Mirtazapine
[21] NHS England ToR pp1-2

- A risk assessment was completed when Mr G was admitted to BDCFT's inpatient unit under Section 2 of the Mental Health Act 1983 (7 February 2017).

- The investigation team noted that during Mr G's inpatient admission in 2015 it was documented that there were incidents of domestic violence/abuse within the family. Additionally, in 2015, it was documented in the risk assessments that prior to the admission, police had seized an extensive armoury of weapons from Mr G. It was also documented and risk assessed that during the admission Mr G had, on several occasions, been in possession of knives and sharp objects. This information was not referred to in the risk assessments that were completed in 2017, completed by the inpatient unit or the involved community mental health teams.

- The risk assessments in 2017 documented that Mr G did not have historic or current mental health needs that co-existed with substance misuse issues. This was despite there being extensive documentation referencing Mr G's historic and more recent substance misuse history, which included illegal and legal highs. There was also no reference to Mr G's substance misuse being a potential significant factor in the deterioration in his physical and mental health.

- Prior to Mr G's transfer to Airedale NHS Foundation Trust's acute inpatient ward, there were numerous incidents recorded of violence and aggression towards both staff and patients, which had triggered the use of rapid tranquillisation and physical restraints. The records also documented that as Mr G's physical health was deteriorating, these risks were escalating.

- A risk assessment was completed on the day Mr G was transferred to Airedale NHS Foundation Trust's acute inpatient ward. This was compliant with BDCFT's Clinical Risk Assessment and Management in Mental Health Policy and Procedures, which directed that a risk assessment review should occur when a patient is being transferred to a different service. There was, however, no evidence that this or any previous risk assessments were forwarded to Airedale NHS Foundation Trust's acute inpatient ward as part of the transfer documentation.

- Clearly, at the time, information-sharing between agencies had to comply with the respective trusts' data-sharing guidance, but BDCFT's Clinical Risk Assessment and Management in Mental Health Policy does provide examples of when information can be shared without the consent of the patient – for example, "where there is evidence of risk of harm either to

the individual or somebody else"[22]. The investigation team have concluded that, as part of the planned transfer to Airedale NHS Foundation Trust's acute inpatient ward, Mr G's BDCFT risk assessments should have been provided in order to inform Airedale NHS Foundation Trust's acute inpatient ward's risk assessments and treatment plan. Additionally, at the point of transfer, a joint risk assessment should have been undertaken to determine the potential risks of Mr G being managed on an acute ward while detained under Section 2 of the Mental Health Act 1983.

Airedale NHS Foundation Trust

During Mr G's inpatient admission to Airedale NHS Foundation Trust's acute ward, the nursing staff completed a number of nursing assessments, including the Airedale International Skin Care Bundle Assessment[23] and the risk of falls. These assessments were reviewed throughout Mr G's admission. The investigation team concluded that all the assessments were completed in line with NICE and Airedale NHS Foundation Trust's guidelines and protocols for a patient who was being treated for sepsis and pressure sores.

The investigation team, however, made a number of observations:

- The assessments were handwritten, and in some cases the handwriting was illegible.

- There was no evidence within the nursing assessments of any documentation relating to Mr G's Section 2 and subsequent Section 3 of the Mental Health Act 1983, such as details of the Approved Clinician.[24] The role of the BDCFT staff observing Mr G was repeatedly referred to as 'carer' and there was no description of their role. Mr G's BDCFT patient records clearly documented that the role of BDCFT's staff caused ongoing confusion and tensions during Mr G's acute hospital admission.

- There was no evidence of Airedale NHS Foundation Trust risk assessing:

- incidents of verbal and physical aggression towards staff

[22] BDCFT's Clinical Risk Assessment and Management in Mental Health Policy and Procedures 2015 p14

[23] The bundle is designed as a resource pack to aid in the assessment and care planning for people at risk of pressure ulcers. The object of the assessment is to prompt consideration of all the health factors involved in maintaining skin integrity when planning care for a patient at risk of pressure damage.

[24] An Approved Clinician (AC) is a healthcare professional who is responsible for the treatment of a patient who has been compulsorily detained under the Mental Health Act 1983. These responsibilities include making decisions about treatment; reviewing detentions; assessing whether the criteria for renewing detention are met; granting leave of absence for detained patients; barring the Nearest Relative from discharging the patient in specific situations; and the power of discharge from detention.

- non-compliance with medication and treatment regimes

- The fact that Mr G was often placing himself in high-risk situations which were exacerbating his physical symptoms – for example, jumping off furniture, causing injuries to himself and refusing to use the pressure-relieving mattress and seat cushions, which was exacerbating the risks to his personal safety and physical health recovery and increasing the risk of him developing further pressure sores and a potentially fatal infection.

- Additionally, both BDCFT's and Airedale NHS Foundation Trust's patient records documented the occasions when physical restraints were being used by both BDCFT and the ward's nursing staff to defuse and safely manage high-risk situations with Mr G. On occasions, the acute ward requested assistance from the hospital security staff in order to prevent a potentially high-risk situation from escalating.

- When Mr G refused P.R.N. (as needed) oral psychiatric medication, such as haloperidol, during such incidents, the acute ward's nursing staff were, at times, administering this medication via intramuscular (hereafter referred to as IM) injections. This method of administering the psychiatric medication was agreed by BDCFT's medical team.

The investigation team noted that although these incidents were being documented in both trusts' patient records, the following information was not being documented:

- Had Mr G given his consent for medication to be administered IM?

- Were physical restraints being used, under the powers set out in the Mental Health Act 1983, which:

  "Provide authority for a mental health professional or a member of the public to act swiftly to prevent a mentally disordered person from causing harm … [and give] legal authority for the treatment of mental disorder without the patient's consent … Where capacity exists, seek the patient's informed consent, taking account of the patient's preferences. Review the treatment plan and consider alternative options if the patient refuses or withdraws consent. Keep the patient's capacity and consent under review. Seek the patient's consent where changes in treatment are proposed."[25]

  Or were such actions being taken using the Mental Capacity Act (2005)[26]?

[25] Mental Health Act 1983
[26] Mental Capacity Assessment

Airedale NHS Foundation Trust's Managing Behaviours that Challenge (and incorporating the use of restraint) Policy (12 February 2018) directed the following:

> "All patients should be assessed comprehensively (taking into cognisance the individual's protected characteristic(s)) in order to establish what sort of therapeutic behaviour management might be of benefit. … The patient's mental capacity is vital to consider. Consent for the use of any type or method of restraint must be gained from patients who have capacity to do so. If a patient either lacks mental capacity to consent to this decision or [is] behaving in a way that presents a risk to others, then the principles of the mental act should be followed. … [The method of restraint should be] Appropriately risk assessed. ... Prior to using chemical sedation there should be an assessment of risk. … [Chemical sedation should be] Appropriately risk assessed, planned, delivered and regularly reviewed by the multidisciplinary team. It should only be used when the risk of not using sedations is greater than the risk of the pharmacological treatment."[27]

There was no documented evidence within Mr G's Airedale NHS Foundation Trust patient records that these directives were followed.

The investigation team is not challenging the individual practitioners' decisions to use physical restraints or administer IM medication either in response to Mr G refusing oral medication, or to manage his behaviours and risks. However, there were concerns that when such actions were being taken, staff were not documenting the rationale and/or referencing the relevant trust policy or legal premise that was being used as the basis for deciding to take such actions.

Clearly, the management of Mr G during his hospital admission to Airedale NHS Foundation Trust's acute ward was complex not least because he was detained under a section of the Mental Health Act 1983, and therefore the management authority and responsibilities of the Approved Clinician remained with BDCFT.

The investigation team concluded that contact and communication between the two trusts' clinicians and nursing staff were generally reactive and in response to crisis situations. BDCFT's Director of Nursing Professional and Care Standards reported to the investigation team that the trust was beginning to develop a protocol with other local hospital trusts to manage patients, like Mr G, who are being transferred between trusts. The investigation team concluded that many of

[27] Acute Hospital's Managing Behaviours That Challenge (and incorporating the use of restraint) Policy 12 February 2018 pp8-9

the issues that developed during the course of Mr G's acute medical ward admission could have been assessed and improved outcomes achieved if a multidisciplinary team care approach had been actioned.

The investigation team would suggest that such a protocol should include:

- arrangements for ongoing communication and information-sharing
- combined risk assessment that is regularly reviewed to jointly assess the risks in relation to a patient's physical and mental ill health
- a joint risk nursing and mental health management plan that includes how to support patients when diagnostic procedures such as ECGs are required
- clarification of who is responsible for undertaking medication reviews to ensure that the patient's physical and mental health symptoms/needs are being effectively managed
- clarification and documentation of the roles and responsibilities of both trusts with regard to the management of the patient's Mental Health Act 1983 sections – for example, the use of rapid tranquillisation and physical restraints – and the use of the Mental Capacity Act (2005).

The investigation team have therefore recommended that the completion of such a protocol should be a priority to ensure that in future when a BDCFT patient is transferred to an acute hospital, an improved seamless approach to care is achieved so that their dynamic risks and mental and physical care needs are being continually assessed and managed.

BDCFT – transfer and discharge- April 2017

Mr G was transferred back to BDCFT's inpatient unit on 21 March 2017, but the next risk assessment was not completed until 8 April 2017. The investigation team would have expected a review of Mr G's risk assessment to have been undertaken at the point he was transferred back to BDCFT's inpatient ward.

BDCFT's Clinical Risk Assessment and Management in Mental Health Policy and Procedures, which were in place at the time, stated that a risk review was required "following any changes in situation"[28]. Clearly, Mr G had been seriously ill and was still at considerable risk of his physical health relapsing, while his mental health was not stable; these risks should have been risk assessed. A risk management plan should have been developed to manage both his physical health – such as post-sepsis care and pressure sore management – and his challenging behaviours and incidents of aggression.

[28] BDCFT's Clinical Risk Assessment and Management in Mental Health Policy and Procedures 2015 p13

Mr G's next risk assessment was prior to his discharge (21 April 2017). The timing of this review was compliant with BDCFT's policy, which states that a risk review should occur when a patient is being discharged from an inpatient admission. However, there were no changes made to the assessment except in the summary, which stated: "20/04/17 Section 3 rescinded and [Mr G] has been discharged."[29]

No further risk assessments were completed when Mr G was subsequently discharged from the community mental health service. The investigation team would suggest that a risk assessment is important at this point to ensure that any risk(s) that a patient may face when services are no longer involved need to be considered and risk assessed. In Mr G's case, if a longitudinal review of his records had been undertaken, it would have indicated that when he was in the community, there was a considerable number of high risks that required further assessment, such as:

- his access to illegal substances and refusal to engage with substance misuse services – based on both historic and recent information, it was known that these likely risks would potentially trigger a significant deterioration in his mental health and an escalation in his aggression

- the ongoing risks with regard to Mr G's physical health, such as pressure sores, the potential risk of further infections due to his low body weight, limited fluid and food intake, sedentary lifestyle, and poor self-care

- the possibility that his medication may be being covertly[30] administered by a member of his family

- Mr G's historic possession of a significant collection of weapons and his recent possession of a knife and other sharp objects

- documented evidence of historic domestic violence within the family where Mr G was both the victim and, on occasions, the perpetrator.

In addition, even if it was not known that Mr G's stepfather had dementia, it should have been evident that Mr G's parents were both elderly and vulnerable.

The investigation team were informed and saw evidence that BDCFT have now introduced the SystmOne[31] patient record system, which includes a new improved risk assessment pro forma. It is comprehensive and a significant improvement on the previous risk assessment tool.

[29] Risk assessment 20 April 2017

[30] 'Covert' is the term used when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them

[31] SystmOne is a centrally hosted clinical computer patient record system SystmOne

The investigation team would recommend that in order to assess how effective the implementation of the new risk assessment has been, BDCFT should undertake a qualitative audit of a substantial number of risk assessments in these services.

6 CQC

BDCFT's Serious incident Report (hereafter referred to as SIR) identified some deficits and omissions in the risk assessments and cited the recent CQC inspection, which concluded that:

"The trust must ensure that staff complete and update regular assessments of need, risk assessments and crisis plans for all patients in line with trust policy."[32]

The investigation team were informed that a CQC inspection undertaken in February 2018 reported:

"Half of the patients' records we looked at did not contain up-to-date risk assessments and some did not have a crisis plan documented for patients. Staff did not monitor physical health needs for all the patients in their care … Some patients did not have up-to-date assessments of their needs and some did not have a personalised care plan. The service did not monitor outcomes for patients and none of the records we looked at had discharge plans in place for patients."[33]

The SIR did not make a specific recommendation, as it concluded that "in order to avoid duplication the issue of staff ensuring risk assessments are updated and reviewed appropriately will be taken forward via the Trust's CQC Action Plan"[34]. It was reported to the investigation team that since this CQC inspection, there has been considerable focus on improving compliance within the inpatient mental health unit. It was however noted that the most recent CQC inspection – 28 February 2019 and 10 April 2019, which involved a review of the acute inpatient wards for adults of working age, psychiatric intensive care units, mental health crisis services and health-based places of safety – concluded:

"Overall ratings went down for the acute inpatient mental health services for adults of working age and the psychiatric intensive care unit to inadequate … Due to the concerns we found during our inspection of the trust's acute inpatient mental health wards for adults of working age and [the] psychiatric intensive

[32] BDCFT's SIR p19
[33] CQC's inspection 12 February 2018 CQC inspection
[34] BDCFT's SIR p19

care unit, we used our powers to take immediate enforcement action. We issued the trust with a Section 29A[35] warning notice."[36]

BDCFT's senior nursing and operational manager reported to the investigation team that in response to the latest CQC inspections, the trust has developed a number of action plans to improve service delivery, risk assessments and care planning, focusing in particular on their inpatient mental health services. Therefore, the investigation team have not made any further recommendations with regard to improving risk assessments and risk management. It is, however, expected that at Sancus Solutions' quality assurance review, BDCFT will be in a position to provide evidence of the progress they have made in implementing their CQC action plan.

7 Pressure sore management

The investigation team were informed by BDCFT that on admission to the inpatient unit, an initial physical health assessment is always undertaken, but it does not generally include a physical examination. Such an examination is only ever undertaken with the patient's consent.

When Mr G was admitted to BDCFT's inpatient unit (7 February 2017), it was noted that he was presenting with low BMI and limited fluid and food intake, and his initial blood screen was indicating possible infection markers. Physical health observations were being undertaken four times a day, but there was no evidence that Mr G was asked for his consent for a physical examination to be undertaken.

Mr G's initial inpatient admission risk assessment noted the following: in the 'harm to self' section, risk of self-neglect was identified in both the 'last six months' and 'ever' sections. The narrative section documented the following: "self-neglect, evident, poor self-care, underweight"[37]. Despite these physical health risks, there was no risk management plan in place, and it was not until 14 February 2017, the day he was admitted to the acute hospital, that the nurses were directed to monitor Mr G's fluid and food intake.

The investigation team concluded that if a more comprehensive physical examination had been undertaken on Mr G's admission to BDCFT's inpatient unit, it might have resulted in his pressure sores being identified and therefore treated earlier. However, it was well documented that both the nursing and clinical staff were facing significant challenges in managing Mr G's presentation

[35] Section 29: A warning notice under section 29A of the Health and Social Care Act 2008 when CQC inspectors identify concerns across either the whole or part of an NHS trust or NHS foundation trust and decide that there is a need for significant improvements in the quality of healthcare Section 29 A

[36] CQC's inspection 28 February 2019 and 10 April 2019 CQC inspection

[37] Risk assessment 7 February 2017 p1

with regard to both his physical and mental health. It was documented that some diagnostic procedures/tests, such as electrocardiogram (ECG)[38] and blood screening, were not undertaken.

The investigation team concluded that on confirmation of an infection being present, the immediate transfer of Mr G to the acute hospital was a proportionate response.

The investigation team did note that there was no specific section in BDCFT's new risk assessment to document and risk assess the service user's physical health. It is well recognised that "people with severe mental illnesses also have significantly higher rates of physical illness with a dramatic effect on life-expectancy"[39]. The investigation team have recommended that to improve the identification and assessment of the complex interrelationship between poor mental and physical health, BDCFT should include a section, in the new risk assessment pro forma, that requires the assessor to identify and assess the potential risks and challenges to the patient's physical health needs.

8 Care planning

"Examine the development and effectiveness of the perpetrator's care plan including both his and his family's input."[40]

Airedale NHS Foundation Trust

The investigation team concluded that Airedale NHS Foundation Trust's acute ward completed comprehensive nursing care plans as part of their Bundle Assessments that were reviewed on a regular basis by the ward nursing staff.

BDCFT

BDCFT provided the investigation team with three care plans:

- 7 February 2017 – when Mr G was admitted under Section 2 of the Mental Health Act 1983
- 8 April 2017 – when Mr G was being discharged from the acute medical inpatient unit, which included a nursing plan to manage his pressure sore treatment
- 21 April 2017 – prior to Mr G's discharge.

[38] An electrocardiogram (ECG) is a test which records the rhythm, rate and electrical activity of the heart ECG
[39] The King's Fund. The Connection between Mental and Physical Health March 2016. The Kings Fund
[40] NHS England ToR p2

The investigation team noted that:

- The care plans' main focus was on Mr G's immediate support needs, such as his pressure ulcer care management. There was, however, little focus on longer-term support needs in relation to Mr G's ongoing mental health needs.

- There was no evidence that Mr G, his family or the GP were invited to contribute to either the care plans or the risk assessments. There was, however, evidence that the GP was receiving copies of discharge plans in which care planning information was documented.

The investigation team concluded that the care plans completed were minimal in content and similar to the risk assessments, as there was no longitudinal assessment or identification of Mr G's ongoing support needs.

Clearly, Mr G had complex and ongoing co-morbidities, involving significant physical health vulnerabilities, the potential risk of substance misuse and associated mental health deterioration. The investigation team would have expected these issues to be documented and assessed within Mr G's care plans.

The investigation team would also have expected that when Mr G's situation changed – for instance, when he was discharged from BDCFT's community mental health services – a comprehensive care plan would be developed.

9 Substance misuse

During Mr G's hospital admission in 2017, the diagnosis of mental and behavioural disorders due to multiple drug use (ICD diagnostic code F199) was given.

The investigation team noted that from Mr G's initial contact with mental health services in 1991 to the incident in 2017, his substance misuse was an ongoing issue and a significant factor in his episodes of mental ill health. It was documented that Mr G was consistently refusing to acknowledge that his substance misuse was a significant contributory factor. He also refused to be referred or to refer himself to community substance misuse services.

Research indicates that 30-50% of people with severe mental illness have co-existing substance misuse problems and that over 70% of people in contact with substance misuse services have co-existing mental health problems.[41]

[41] Weaver, T., Charles, V., Madden, P., Renton, A. (2002) Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC): A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Department of Health/National Treatment Agency, London. Co morbidities

It is also suggested that substance misuse may be being used as a form of self-medicating, and therefore their underlying mental health symptoms may be obscured or exacerbated.

The nature of the relationship between these two co-morbidities is complex. In Mr G's presentation, it was evident that his substance misuse had a significant destabilising and detrimental effect on both his mental and physical health and possibly on the effectiveness of the medication he was being prescribed.

Research and various governmental substance misuse guidance have consistently highlighted that successful support and management of patients who are presenting with a complex combination of mental health and alcohol and substance misuse issues can only be achieved:

"Through partnerships across services particularly housing, employment and mental health services … agreed pathways of care will enable collaborative care delivery by multiple agencies … Coordinated multi-agency plans, collaboration and good communication between services are important to ensure patients do not fall between the gaps."[42]

A review of Mr G's patient records highlighted that there was little consideration of the possibility that his significant substance misuse problem required a coordinated interagency response. The investigation team have recommended that to improve the outcomes for patients, such as Mr G, who have significant and ongoing substance misuse issues and who refuse to engage with external substance misuse services, BDCFT inpatient and mental health community services should consider undertaking a review of how they currently manage such patients.

10 Record-keeping and interagency communication

"Review the standard of record keeping, identifying any opportunities for improvement.

Review and assess interagency communication between services regarding compliance with local policies, national guidance and relevant statutory obligations identifying any opportunities for improvement."[43]

BDCFT

At the time of Mr G's involvement, BDCFT was using an electronic patient record system, and therefore the records were very accessible. However, many of Airedale NHS Foundation Trust's records were handwritten, and some entries

[42] Drug Strategy 2017
[43] NHS England ToR p1

were difficult to read due to the standard of the handwriting of some of the clinical and nursing staff.

What was of considerable concern to the investigation team was that details of two significant and potentially harmful safeguarding incidents, which were witnessed by BDCFT staff when Mr G was a patient of Airedale NHS Foundation Trust – when a member of Mr G's family was observed covertly giving Mr G his medication without his consent – were only documented in Mr G's BDCFT patient records. The records stated: "I also informed the nurse looking after Mr G of my concerns … Consultant and FY1 were also present when this was happening."[44] The investigation team were unable to ascertain which Airedale NHS Foundation Trust staff were reportedly informed, but all staff who were interviewed reported that they were not made aware of these incidents and that if they had been, they would have taken action under the trust's safeguarding guidance. The lack of documentation resulted in Airedale NHS Foundation Trust's staff failing, albeit unwittingly, in their safeguarding responsibilities.

Due to operational issues, BDCFT staff were undertaking two-hourly shifts of monitoring Mr G on the acute ward, and therefore the investigation team would suggest that it was impractical and unrealistic to expect that at the end of each shift, there would be a formal handover to the acute hospital nursing staff. The investigation team have identified several possible solutions that could have easily been actioned to resolve this issue and to ensure that, in the future, information is shared and documented when a BDCFT mental health patient is on Airedale NHS Foundation Trust's ward. For example:

- As Airedale NHS Foundation Trust uses handwritten nursing notes, an entry could have been made by BDCFT's staff member at the end of their observation shift and inserted into the nursing notes section of the acute hospital records.

- A copy of the entry made in the BDCFT patient records could be sent to the ward and inserted into their nursing records.

The investigation team would suggest that the protocol that is being developed with other local acute trusts to manage patients, like Mr G, who are transferred between trusts should include how information is shared and documented.

Primary care

In 2018 BDCFT changed its electronic patient records to SystmOne. It was reported that one of the significant advantages of this system is that most GP services in the area also use this patient record system. The ultimate aim is for all local services to have at least partial access to other agencies' records via

[44] BDCFT's patient records 13 March 2017

SystmOne. Clearly, this has great advantages with regard to information-sharing and providing seamless care to patients.

BDCFT reported to the investigation team that although some of their services, such as the tissue viability service, do have full access to GP patient record systems, there continue to be some challenges that the trust is in the process of resolving relating to both data protection and information-sharing.

11 Capacity and resources

"Identify issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and to work effectively with other agencies."[45]

Apart from the pressure of BDCFT providing staff to maintain 24-hour observations of Mr G while he was an inpatient at Airedale NHS Foundation Trust's hospital, there were no capacity issues identified by either BDCFT's SIR or this investigation.

West Yorkshire Police's Individual Management Review (hereafter referred to as IMR)[46], which was completed as part of this investigation, documented that there was "no evidence that there were any capacity issues in the initial police response"[47].

12 Dispensing error

As has already been documented, during the police's investigation it was found that in the weeks prior to the incident, there had been a dispensing error by the community pharmacist. It was reported that on the day the dispensing error occurred, the dispensing pharmacy had been remarkably busy and there had been an altercation between Mr G and his mother, which had caused some distraction for the dispensing team.

It is not known if Mr G actually took any of the mirtazapine and, if so, how many. It is also uncertain whether he had any olanzapine left over from previous prescriptions. During the police investigation, it was reported that Mr G stated that he did not believe he took his medication the night before the incident on 8 September 2017.

[45] NHS England ToR p1
[46] An IMR is a report detailing, analysing and reflecting on the actions, decisions, missed opportunities and areas of good practice within the individual organisation IMR
[47] West Yorkshire Police's IMR p46

The investigation team concluded that based on the assumption that Mr G had been taking his olanzapine as prescribed, prior to the mirtazapine being dispensed, it would have been excreted from his body within 32 hours.

The British National Formulary[48] directs that:

> "Withdrawal of antipsychotic drugs after long-term therapy should always be gradual and closely monitored to avoid the risk of acute withdrawal syndromes or rapid relapse. Patients should be monitored for 2 years after withdrawal of antipsychotic medication for signs and symptoms of relapse."[49]

Clearly, Mr G's withdrawal from this medication was neither gradual nor closely monitored. Therefore, it is highly likely that this would have contributed to the re-emergence of Mr G's mental health symptoms, and that this dispensing error was one of the contributing factors to the tragic events on 8 September 2017.

The investigation team undertook a review of the community pharmacist's near-miss[50] data and dispensing errors.[51] It was concluded that although totally eliminating all dispensing errors is unrealistic, such errors can be minimised, primarily through investigations and an open and honest near-miss reporting culture. The investigation team suggest that ongoing identification and investigation of such dispensing errors should be viewed as an opportunity to identify why an error has occurred and what remedial action is required. Such a culture of inquiry should lead to improvements in practice and ultimately patient safety.

The investigation team have recommended that NHS England and NHS Improvement (North East and Yorkshire) should report the findings of this report to the Royal Pharmaceutical Society and the General Pharmaceutical Council.

13 Carer's assessment

"Review and comment on if carers assessments for family members, providing support to the perpetrator, were adequate and effective"[52].

It was extensively documented that post inpatient admission, Mr G's mother and, to a lesser degree, his stepfather were involved in supporting Mr G's mental

[48] British National Formulary (BNF) is a United Kingdom pharmaceutical reference book that contains information and advice on prescribing and pharmacology BNF
[49] Olanzapine
[50] A dispensing near miss in a pharmacy is an error that has been identified as part of the normal checking process and prior to the medication being dispensed to the patient.
[51] A dispensing error is an error that involves the wrong medication being dispensed to a patient and therefore has the ability to cause harm.
[52] NHS England ToR p2

health. It was also documented that his mother was involved in her son's physical health issues both in the community and while he was an inpatient.

What is now evident is that during 2017, not only was Mr G's mother providing emotional support to Mr G, but she was also supporting her husband, who had recently been diagnosed with dementia. In addition, she had a number of vulnerabilities.

A review of BDCFT's current website highlights multiple sources of support for carers and the trust's ongoing commitment to implementing the key elements of the Triangle of Care[53].

Based on the information available, it appears that there were two occasions in 2017 when BDCFT's practitioners documented that they had discussed with Mr G's mother her accessing carers' support. There was no indication if she pursued this support.

There was no indication that Mr G's stepfather was offered and/or provided with details of carers' support services. The investigation team consider that this was an oversight, as he was also living in the household, and at times it was documented that he was struggling to manage Mr G's mental health issues.

14 Safeguarding and domestic abuse

"Identify any safeguarding concerns involving the perpetrator or victim and determine if agencies responses and actions were adequate and compliant with local policies including regional safeguarding policy (West Yorkshire, North Yorkshire and York, safeguarding policy and procedures (2015) or previous if appropriate (2013)), national guidance and relevant statutory obligations.

Establish what lessons can be learned from the domestic death regarding how professionals and organisations operate both individually and together to safeguard future victims.

Identify from both the circumstances of the case and the multi-agency involvement whether there is learning which should inform future local and national policies and procedures relating to domestic homicides."[54]

[53] The Triangle of Care offers key principles and resources to influence services and other people working with carers to be more effective in involving them within acute care. The Triangle of Care is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains well-being. Triangle of Care

[54] NHS England ToR p2

Mr G's stepfather

In December 2016, Mr G's stepfather was given a diagnosis of Alzheimer's disease.[55] After assessments by BDCFT's memory assessment and treatment service[56] (hereafter referred to as MATS) he was discharged to the care of his GP. There was no indication from his GP patient records that Mr G's stepfather saw his GP after his diagnosis.

The investigation team concluded that Mr G's stepfather's diagnosis and initial treatment plan were appropriate and proportionate to his presentation.

It was, however, of concern to the investigation team that Mr G's stepfather's assessment did not identify the following issues:

- his stepson's recent mental health difficulties and the fact that he was, at the time, under a Mental Health Act 1983 section and was being treated for a life-threatening infection

- the recent involvement of the police in an incident involving Mr G and his stepfather.

It was also noticeable that there was no mention within Mr G's BDCFT or Airedale NHS Foundation Trust patient records of his stepfather or the fact that he had recently been assessed for and diagnosed with dementia.

Clearly, if Mr G and his parents had chosen not to disclose the extent of the difficulties the family was experiencing, then it was their right to do so.

During the elderly service's assessment of Mr G's stepfather, a risk assessment was completed. No risk of harm to others or from others was documented. There was no evidence to indicate whether the assessor made enquiries about the mental health of other members of the family and the involvement of services. If this had occurred, information about Mr G's historic and more recent mental health, risk and substance misuse histories may well have come to light, which would hopefully have identified the need for the assessor to obtain further information to assess the possible risks to Mr G's stepfather.

The investigation team were informed that it is not a formal component of a MATS assessment to enquire about the mental health of other members of the family, as the service is primarily diagnostic and treatment focused.

[55] Alzheimer's disease is the most common type of dementia in the UK. It affects multiple brain functions. Alzheimer's disease
[56] BDCFT MATS service

In hindsight, it is evident that in 2017 this was clearly a family experiencing considerable distress, with two members having acute and long-term mental health and behavioural difficulties. If this information had been known, it should have prompted both a multi-agency response and an assessment of the support needs of the family.

The investigation team are recommending that BDCFT adult and elderly mental health services' memory clinic should undertake a review of its assessment processes to consider if there needs to be a comprehensive psychosocial assessment of the patient and their family situation.

In June 2015, while Mr G was a patient of BDCFT, he made a number of allegations that he had experienced physical, emotional and financial abuse from a member if his family who he was living with. Mr G's mother confirmed that some of her son's accusations were true. These disclosures prompted the inpatient unit, with Mr G's consent, to make an adult safeguarding alert to the local authority. A social worker commenced a safeguarding investigation, which concluded that there was some evidence to support Mr G's allegation of financial abuse but that no further safeguarding action would be taken.

The investigation team concluded that the safeguarding alert and subsequent investigation in 2015 was proportionate and compliant with BDCFT's policy. However, they had concerns that Mr G's subsequent risk assessments did not document the allegations or undertake any assessment of current risks of potential abuse.

As has already been documented, the investigation team had considerable concerns with regard to the lack of safeguarding reporting/action by both BDCFT's and Airedale NHS Foundation Trust's staff, who witnessed a member of Mr G's family covertly giving Mr G his medication.

15 Domestic violence

A member of Mr G's family reported to the police several incidents of domestic abuse involving physical, verbal and at times threatening abuse.

BDCFT's safeguarding policy defines domestic violence as "including psychological, physical, sexual, financial, emotional abuse"[57]. The policy gives directions for how practitioners are required to respond to either suspected and/or known incidents of abuse.

The investigation team were of the opinion that there was enough known historic and more recent evidence of potential domestic violence that action should have

[57] BDCFT's Safeguarding Adults Policy and Procedure (2016) p14

been taken by the involved BDCFT services, both at the point the information was known and on an ongoing basis, to:

- assess the possible ongoing risk factors within the risk management and care planning processes

- seek the advice of the trust's safeguarding team.

The investigation team have recommended that both BDCFT and Airedale NHS Foundation Trust review their safeguarding training modules to ensure that staff understand, as West Yorkshire Police's IMR highlighted:

"The potential risks of elderly people becoming victims of domestic abuse from their children or other younger relatives who have mental ill health issues … [Elderly people] may be at a higher risk of harm particularly where they co-reside, and this should be reflected in risk assessments, referrals and other safeguarding action."[58]

16 West Yorkshire Police's Individual Management Review

Sancus Solutions requested that West Yorkshire Police's Safeguarding Central Governance Unit[59] complete an IMR to document and comment on their involvement with Mr G and his family.

The police's IMR highlighted a number of issues in West Yorkshire Police's responses to their involvement with Mr G and his parents. Their last involvement was six days before the incident.

- The police received a telephone call from Mr G's mother, who reported that her son was "wrecking their house and had a knife"[60] and that she and her husband "had barricaded themselves in their bedroom"[61]. On arrival the police found Mr G in possession of a seven-inch hunting knife. He was arrested for the offence of possessing an offensive weapon in a public place. Mr G was subsequently released with a Conditional Caution[62], with the condition that he was not to be in a public place with a "sharp pointed article for the period ending inclusive of 30/09/17"[63].

[58] West Yorkshire Police's IMR p46
[59] West Yorkshire Police Authority
[60] West Yorkshire Police's IMR p21
[61] West Yorkshire Police's IMR p21
[62] A Conditional Caution is issued if the offender admits the offence and accepts the condition(s). If the conditions are complied with or completed within the timescales determined, the case is finalised and there is no prosecution. If, however, the conditions are not complied with, a prosecution may follow. Conditional Caution
[63] West Yorkshire Police's IMR p22

The IMR documented that the attending officer described how "at this time the unit was under strength and officers were required to deal with a large volume of detainees with an emphasis on expedition. Part of this was the use of non-charge disposals where appropriate, for example conditional cautions."[64]

The authors of the IMR concluded this "may have diluted the officer's ability to consider [Mr G's mother's and stepfather's] welfare and the risk of harm to them from [Mr G]. However, the officer did speak to [Mr G's mother] and discuss with her the appropriateness of [Mr G] returning to her address after he was cautioned. It was documented that she fully supported this and reassured the officer that she did not believe [Mr G] was a danger to her and [Mr G's stepfather]."[65]

The IMR noted the following issues.

- "No enquiries were made by the attending officers to determine if [Mr G] had possession of other weapons."[66]
- "There was no exploration of Mr G's "antecedents, discussion of his mental state or consideration of the risk which he posed."[67] As this was not assessed as a domestic incident, no DASH risk assessment[68] was undertaken that "would have identified and assessed the potential risk(s) of harm"[69] to Mr G's mother and stepfather.

The investigation team concluded that the police IMR was comprehensive and that the recommendations were proportionate and adequate.

The investigation team have recommended that to facilitate and encourage interagency learning from this case, West Yorkshire Police should provide BDCFT and Airedale NHS Foundation Trust with their IMR's findings and recommendations.

17 Mr G's mother's complaint

On a number of occasions during Mr G's admission to Airedale NHS Foundation Trust, his mother voiced her concerns about the mattresses being on the floor, reporting that she had observed the nursing staff walking on them.

[64] West Yorkshire Police's IMR pp26-27
[65] West Yorkshire Police's IMR pp26-27
[66] West Yorkshire Police's IMR p21
[67] West Yorkshire Police's IMR p21
[68] The DASH [Domestic Abuse, Stalking & Harassment, & Honour Based Violence] risk assessment is for all professionals working with victims of domestic abuse, stalking and harassment, and honour-based violence. DASH includes a risk checklist for victims of domestic abuse, stalking and honour-based violence. DASH
[69] West Yorkshire Police's IMR p21

Although the investigation team could appreciate Mr G's mother's concerns, given the significant physical risks of Mr G's ongoing refusal to sleep in a bed, they concluded that the actions taken to minimise the considerable risks were proportionate.

The lack of access to low beds was a resource issue, and Airedale NHS Foundation Trust reported to the investigation team that since this incident, they have secured more low beds, so it is hoped that in the future this situation will not occur.

The investigation team would suggest that if in the future BDCFT or Airedale NHS Foundation Trust makes the decision to place a mattress on the floor, then the risks need to be fully assessed, the rationale for the decision fully documented within the patient's risk assessment and management plan, and the rationale explained to the family.

18 Predictability and preventability

"Determine through reasoned argument if this incident was either predictable or preventable, providing detailed rationale for the judgement."[70]

Predictability

The investigation team have concluded that the historic and more recent incidents of domestic violence indicated that there were a number of complex relationships within Mr G's family, which involved both physical and verbal threats. There was also an increase in such incidents when Mr G's mental health was deteriorating. Given how unstable Mr G's mental health could become, especially when he was using illegal substances, the investigation team concluded that it was predictable or at least highly likely that there would be further incidents of domestic violence within this family.

Preventability

The investigation team have concluded that if the potential risks to Mr G's elderly parents and information about Mr G's historic and more recent mental health difficulties had been obtained and adequately assessed, it is likely that it would have prompted a multi-agency assessment and response. Whether this action would have resulted in Mr G's risks being assessed as being high enough to justify Mr G's removal from the family home is uncertain.

In the assessment of both the predictability and the preventability of the event on 8 September 2017, it has to be considered that a dispensing error had been

[70] NHS England ToR p2

made on 21 August 2017, and the possible effects that Mr G might have been experiencing and the potentially increasing his risk factors.

However, due to the uncertainty of whether Mr G was actually taking this medication, the investigation team do not feel able to definitively conclude that this was a significant contributory factor in the predictability and/or preventability of the incident.

19 BDCFT's Serious Incident Report

"Review the trust and any other agencies' post incident internal investigations and assess the adequacy of their findings, recommendations and action plans.

Review the progress that the trust and any other involved agencies have made in implementing their action plan(s) associated with their internal investigations."[71]

The investigation team concluded that BDCFT's post-incident SIR was comprehensive, professionally written and adequately addressed their ToR.

The major concern for the investigation team was the lack of a critical analysis of the initial identification and subsequent management of Mr G's pressure ulcers by BDCFT's inpatient unit. The author of the SIR informed the investigation team that this was not an area that had been specifically identified within the ToR.

The investigation team concluded that this was a significant deficit in the ToR, as such an analysis would have focused on the complex risks that Mr G was presenting and the management of patients, like him, who have mental and acute physical health issues. The investigation team would suggest that valuable lessons could have been learned if such an analysis had been undertaken.

The SIR made six recommendations and provided the investigation team with an updated action plan and associated evidence. The investigation team were satisfied that BDCFT had actioned and completed all of the SIR's recommendations.

20 Duty of Candour and Being Open principles

[71] NHS England ToR p2

The investigation team concluded that based on the evidence provided, BDCFT met its Duty of Candour[72] and Being Open[73] statutory responsibilities with regard to its communications with, and the support it provided post-incident and during the SIR process to, Mr G and his mother.

21 Concluding comments

This was clearly a very tragic event which continues to deeply affect the lives of all those involved. Although this investigation report has highlighted some deficits in the care and treatment of Mr G, the investigation team is not suggesting that any individual practitioner was directly responsible for this tragic event.

The investigation team hope that the findings and recommendations of their investigation will contribute to the learning and development of all the involved agencies and practitioners and will improve their practices and the service delivery to both this vulnerable patient group and elderly parents who are caring for members of their family who are experiencing significant mental health issues.

22 Recommendations

Bradford District Care NHS Foundation Trust

Recommendation 1: Bradford District Care NHS Foundation Trust should continue to develop and implement a protocol with local acute NHS trusts that adopts a multidisciplinary and multi-agency approach to the care and treatment of patients who require the involvement of multiple services – particularly patients who are detained under a section of the Mental Health Act 1983 and who also require an acute hospital admission.

The trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

[72] CQC Regulation 20 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. Regulation 20 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 and providing truthful information and an apology when things go wrong. Duty of Candour

[73] Being Open: acknowledging, apologising and explaining when things go wrong; conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring; providing support for those involved to cope with the physical and psychological consequences of what happened. Being Open

Airedale NHS Foundation Trust

Recommendation 2: Airedale NHS Trust should introduce a risk summary where relevant risk information that has been obtained from other involved services, family members and carers is documented. The risk summary should be reviewed throughout a patient's admission and/or when new information becomes available.

When it is known that a patient has been involved with mental health services this should, with the patient's permission, prompt the assessor to obtain information from these services to inform Airedale's risk summary.

The Trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Bradford District Care NHS Foundation Trust

Recommendation 3: Bradford District Care NHS Foundation Trust should undertake a qualitative audit of a large sample of risk assessments in their community and inpatient adult mental health services.

The trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Bradford District Care NHS Foundation Trust

Recommendation 4: Bradford District Care NHS Foundation Trust's risk assessment pro forma should be revised so that it includes the identification and assessment of the potential risks to a service user's physical health and their associated support needs.

The trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Bradford District Care NHS Foundation Trust

Recommendation 5: Bradford District Care NHS Foundation Trust should provide evidence at Sancus Solutions' quality assurance review of the progress they have made in implementing their CQC action plan with regard to improving risk assessments and care planning within their inpatient and community mental health services.

Bradford District Care NHS Foundation Trust

Recommendation 6: Bradford District Care NHS Foundation Trust should undertake a review of how they assess and support patients in their inpatient and community

services who have a significant substance misuse problem and who refuse to engage with external agencies.

The trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

Bradford District Care NHS Foundation Trust

Recommendation 7: Bradford District Care NHS Foundation Trust's adult and elderly mental health services' memory clinic should introduce a comprehensive psychosocial assessment of the patient, their family's situation and potential risk factors.

The trust should provide evidence at Sancus Solutions' quality assurance review that this recommendation has been implemented.

NHS England

Recommendation 8: NHS England should report the findings of this report that relates to the dispensing error to the Royal Pharmaceutical Society and the General Pharmaceutical Council.

Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust

Recommendation 9: Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust should undertake a review of their safeguarding training modules to ensure that the potential risks of domestic violence to the elderly are being adequately addressed.

Evidence of this should be made available to Sancus Solutions at their quality assurance review.

West Yorkshire Police

Recommendation 10: To facilitate and encourage interagency learning from this case, West Yorkshire Police should provide Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust with their IMR's findings and recommendations.

Appendix 1 Terms of Reference

Purpose of the investigation

To identify any gaps, deficiencies or omissions in the care and treatment received by the perpetrator [Mr G] and the victim which could have predicted or prevented the incident on 8 September 2017.

The investigation will identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from May 2015 to the incident occurring on 8 September 2017.

The outcome of the investigation is to be managed through corporate governance structures within NHS England and in conjunction with other key stakeholders through their appropriate board or committee.

Terms of Reference

Involvement of the affected family members and the perpetrator

- Ensure that all affected families are informed of the investigation, the investigative process and understand how they can contribute; agree how updates on progress will be communicated.
- Offer a meeting to the perpetrator so that he can contribute to the investigation process.

Care and treatment

- Undertake a review of care and treatment provided to the perpetrator by the NHS, the local authority and other relevant agencies, including compliance with local policies, national guidance and relevant statutory obligations.
- Review the standard of record keeping, identifying any opportunities for improvement.
- Review the appropriateness of the care and treatment of the victim, leading up to the incident, in the light of any identified health and social care needs.
- Identify issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and to work effectively with other agencies.

Risk assessment and care planning

- Review and assess the risk assessments and risk management undertaken by all agencies, including the review of the risk of the perpetrator harming himself or others and determining compliance with local policies, national guidance and relevant statutory obligations.
- Review how risk information was shared and escalated between the involved agencies to determine if this was appropriate, timely and effective.

- Examine the development and effectiveness of the perpetrator's care plan including both his and his family's input.

Interagency communication

- Review and assess interagency communication between services regarding compliance with local policies, national guidance and relevant statutory obligations identifying any opportunities for improvement.

Carer's assessment

- Review and comment on if carers assessments for family members, providing support to the perpetrator, were adequate and effective.

Safeguarding and Domestic Abuse Issues

- Identify any safeguarding concerns involving the perpetrator or victim and determine if agencies' responses and actions were adequate and compliant with local policies including regional safeguarding policy (West Yorkshire, North Yorkshire and York, safeguarding policy and procedures (2015) or previous if appropriate (2013)), national guidance and relevant statutory obligations.
- Identify if the victim's family and friends knew of any domestic abuse within the family composition and if so, what did they do with that information.
- Establish what lessons can be learned from the domestic death regarding how professionals and organisations operate both individually and together to safeguard future victims.
- Identify from both the circumstances of the case and the multi-agency involvement whether there is learning which should inform future local and national policies and procedures relating to domestic homicides.

Predictable and preventable

- Determine through reasoned argument if this incident was either predictable or preventable, providing detailed rationale for the judgement.

Serious Incident Review

- Review the trust and any other agencies' post incident internal investigations and assess the adequacy of their findings, recommendations and action plans.
- Review the progress that the trust and any other involved agencies have made in implementing their action plan(s) associated with their internal investigations.

Outputs

- Provide a final written report to NHS England that is easy to read (meets NHS England accessible information standards) within six months of receipt of all clinical and social

care records and follow with a set of measurable and meaningful outcome focused recommendations.

- Deliver an action planning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to service users, carers, victims and others with a legitimate interest.
- Share the findings of the report, in an agreed format, with the affected families and the perpetrator, seek their comments and ensure appropriate support is in place ahead of publication.
- Consider holding a learning event for involved practitioners and services to share the report's findings and recommendations.
- Conduct an assurance follow up visit with key stakeholders, in conjunction with the relevant CCG, six months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short written report, for NHS England, which will be shared with families and stakeholders and will be made public.

Appendix 2 Sancus Solutions' investigation team

- Grania Jenkins was the lead investigator and author of the report. Grania has a background as a mental health practitioner and a senior manager for adult and children's and young people's mental health services. She has also worked in senior management positions in performance and quality within the health and social care sectors. Grania has extensive experience of undertaking high-profile and complex homicide investigations, under NHS England's Serious Incident Framework, in which the victim and/or perpetrator was a child/young person. Grania holds a police qualification for investigating complex and serious crimes (PiP 2) and has undertaken training in family liaison support.
- Richard Brown, MRPharmS, Chief Officer, Avon Local Pharmaceutical Committee (LPC), is a qualified pharmacist with nearly 25 years' experience in community pharmacy services in a wide range of roles, including pharmacy manager, Area Manager, and Operations Manager with responsibility for Clinical Governance. Richard has also worked with public health departments, Clinical Commissioning Groups and NHS England to ensure pharmacies are fit for purpose and delivering service to the required standards. This also includes being present on a number of committees, including Shared Care Committees that provide the governance and scrutiny of services delivered to clients suffering from substance misuse.
- Tracey Gunning co-led the investigation. Prior to her retirement, Tracey worked as a mental health nurse and ward manager in acute inpatient services. She also worked for many years in local authority social care services and has extensive experience of undertaking serious incident investigations within the NHS and local authority services.
- Ray Galloway assumed the role of family liaison officer. Prior to retirement, Ray was a detective superintendent in the police force. He was then appointed as one of the independent investigators into the activities of Jimmy Savile. In this investigation, Ray has acted as the critical friend, providing a level of independent scrutiny to the investigation. He was also the independent point of contact for the family.
- Tony Hester provided the quality control and governance oversight of the investigation process. Tony is one of the directors of Sancus Solutions. Tony has over 30 years' Metropolitan Police experience in specialist crime investigation. Since 2009, Tony has coordinated and managed numerous domestic homicide reviews for Sancus Solutions where the mental health of the perpetrator and/or victim has been a significant and contributory factor