VERITA

Independent investigation into the care and treatment of Ms A provided by a Mental Health Foundation Trust

Executive Summary of a report for NHS England (North West region)

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1. Executive summary and recommendations

Introduction

1.1 The victim was killed by Ms A, a woman who had no connection to her on 22 March 2020. Ms A subsequently pleaded guilty to manslaughter on the grounds of diminished responsibility. Ms A had been a patient of a mental health NHS foundation trust ('the trust') before the incident.

1.2 An internal investigation carried out by the trust was completed in October 2020. In March 2021 NHS England North West Region commissioned Verita to carry out this independent review of Ms A's care and treatment under the NHS Serious Incident Framework (2015). We were assisted by an expert who is the chief medical officer at The Huntercombe Group and Active Care Group, and a former clinical director at Broadmoor High Secure Hospital.

1.3 We collected evidence, reviewed documents and carried out interviews and we spoke to the victim's father, on behalf of her family. In some instances, the facts of this case were difficult to confirm, either because they were not fully established at the time or not recorded fully. We have tried to set out as clearly as possible which facts are established and identify issues which are unclear.

1.4 NHS England have told us that this Executive Summary is being published to provide the reader with an overview of our full report in order to allow readers to understand the findings and the learning identified in a concise and easy to read document. The evidence on which our findings are based is set out in the full report.

Background

1.5 The main events in Ms A's care and treatment are:

- November 2014 – Ms A first referred to the mental health trust by her GP. She was treated as an outpatient.
- July 2015 - Following an incident when she was found holding a knife and expressing anxiety that she was being harmed by her neighbours, Ms A was admitted to an acute mental health ward at a hospital (part of the trust). She

was detained under the Mental Health Act 1983 for treatment for seven weeks. She was diagnosed with acute schizophrenia like psychotic symptoms. Following discharge, she was cared for by the trust's Early Intervention Team (EIT).

- February 2017 – Ms A was again admitted to the same ward at the hospital and detained there, this time following a violent attack on a family member. During her stay she spent time on a psychiatric intensive care unit in the hospital.
- May 2017 - Ms A was discharged home on a Community Treatment Order (CTO).
- October 2017 – Ms A's CTO renewed for a further six months.
- May 2018 – Ms A was discharged from her CTO by her consultant psychiatrist.
- December 2018 - Ms A transferred from the Early Intervention Team to the Community Mental Health Team (CMHT), which continued to be responsible for her care and treatment until March 2020.
- March 2020 – incident took place.

1.6 The trust is a large organisation with 6,500 staff across more than 150 locations. The trust provides inpatient and community-based services. While a patient of the Early Intervention Team and Community Mental Health Team, Ms A was under the care of a care co-ordinator and a consultant psychiatrist. The care co-ordinator is usually a registered mental health nurse or a social worker. They carry out assessments of patients (including assessing risk), check compliance with medication and liaise with the other services that work with the patient. The consultant psychiatrist has overall clinical responsibility for the patient and is the responsible clinician. The Early Intervention Team provides treatment and support to people experiencing (or at high risk of) developing psychosis for the first time, usually for up to three years.

1.7 The trust follows a Care Programme Approach (CPA). The approach provides a framework to ensure assessment, formulation, care planning, review and multi-disciplinary team working. It also follows a 'recovery model' which is common across the NHS and is based on the principles that it is possible to recover from mental health conditions and that patient-directed recovery is the most effective.

Ms A's medication

1.8 During the time covered in this report, Ms A showed varying degrees of compliance with medication. There were also many changes to her medication. Reasons for the changes

included the search for the most effective medication and because Ms A suffered from side-effects which were at times severe. A key issue with her medication was whether it would be administered by injection (known as 'depot' medication) or orally (e.g. tablets).

Key events and issues

Admission in 2015

1.9 On 2 July 2015, Ms A was found outside her house at 3am holding a knife. She was reported to be very frightened and was shouting at one of their neighbours, an elderly lady. She was taken to A&E and a Mental Health Act assessment was carried out. The assessment recorded her as a risk to herself, but not to others. She was subsequently detained under Section 2 of the Mental Health Act (which allows for a person to be detained for assessment and treatment for up to 28 days).

1.10 Ms A appealed unsuccessfully against her detention on 22 July. The psychiatric report stated that there was "*no evidence*" she presented any "*current risk*" to others. Subsequent records also referred to their being no current risk. Given her history, it was incorrect to say there was no evidence that Ms A presented a risk to others. In our view, the focus on "*current risk*" was unhelpful as it failed to differentiate between her risk profile and her condition at a particular moment. Ms A was potentially dangerous when unwell. This risk continued to exist and the fact that Ms A was well at the time that an assessment was carried out is irrelevant to it. The way her risk was described therefore obscured the real risk level.

1.11 Ms A was subsequently discharged from inpatient care on 20 August 2015. Her discharge summary records a "*possible risk of aggression to others*".

1.12 It was clear from the incident in 2015 that, when unwell, Ms A posed a risk of violence. This was well understood by those who treated her in hospital in 2015. However insufficient attention was given to this risk subsequently.

Risk assessments by the Early Intervention Team

1.13 A risk assessment of Ms A was carried out in August 2015 by a member of the Early Intervention Team. The box relating to the risk of '*actual or potential harm to others*', identified that Ms A had a *"Past History"* of this. The assessment also includes an accurate summary of the incident in July, including reference to Ms A being armed with a knife.

1.14 A later section in the August assessment is entitled '*Summary of Current Risk*' which, it states, relates to the "*degree of effort and intervention required to prevent risk*". There are three choices, '*Red*', '*Amber*' or '*Green*'. '*Green*' is described as "*Low Risk – routine or usual intervention; routine frequency of reviews*". The assessment marks Ms A as Green in all categories, including risk of violence.

1.15 A further risk assessment was carried out in conjunction with a care plan for Ms A in February 2016. The care plan summarises Ms A's admission to hospital. It gives a reason for admission which makes no reference to a knife. In the risk assessment the sections '*Actual or attempted harm to others*' and '*Threats to harm others*' are marked "*Past History Only*". The '*Formulation of Risks*' in the document says there are no current issues with mental health.

1.16 It is noticeable that, over time, the description of the incident in July 2015 becomes much less detailed. In addition, the risk documentation focuses attention on current presentation, rather than events that happened some time ago, with a choice forced between "*current*" risks and "*past history*". The overall effect is that the level of assessed risk appears to be significantly reduced.

Admission in 2017

1.17 On 11 February 2017, Ms A and three family members met for a reunion. Accounts of the day are contradictory, but at some point, a family member (B) went upstairs to a bedroom. Initially, Ms A sat quietly downstairs, but then went upstairs to the bedroom and locked the door from the inside. Ms A then hit B on the head with an iron and started biting her. Another family member (C) broke the door open and saw B covered in blood from a

wound caused by the biting. C's understanding is that at the moment of the attack, Ms A believed that there was someone who was impersonating B who had come to kill her.

1.18 Our expert described this as "*classic relapsing remitting paranoid schizophrenia … making up her mind what to do on the basis of mis-identification*". Our expert believes there were factors about Ms A's presentation that made her particularly risky:

1. Formal thought disorder was not an obvious part of her presentation
2. She did not speak English as a first language, which makes small changes in language usage, which can be an indicator that something is wrong, harder to spot
3. She was generally a reticent person so that the introspection described immediately before the incident was not out of character.

1.19 Together these factors might have made it difficult to identify when Ms A was unwell.

1.20 Ms A was admitted to the same hospital where, on 13 February 2017, a Mental Health Act assessment was carried out. The assessment recorded the details of the violent incident and described Ms A's principal psychiatric need as "*psychosis/schizophrenia*". Ms A was subsequently held under Section 2 of the Mental Health Act.

1.21 Ms A absconded a number of times in subsequent days. On one occasion she went to the house of another service user. The records are unclear, but she may have previously attempted to obtain a knife before asking to see the service users' early teen-age daughter. A mental health assessment report was carried out by an Approved Mental Health Professional on 15 March 2017. A box marked 'Adult/Child Safeguarding Concerns' was ticked on that form, with the text:

> *"Report that prior to return to hospital [Ms A] had attended a friend's house at 05:00 requesting to see … the friend's young daughter, and that immediately prior to this she has attended a food outlet/restaurant asking for a knife."*

1.22 The safeguarding team did not believe that there was a safeguarding issue as Ms A was an inpatient under Section 2 of the Mental Health Act.

1.23 Ms A was transferred to a Psychiatric Intensive Care Unit (PICU) to reduce the risk of further absconding. She was given a depot injection. As she refused the medication, she had to be restrained while it was administered.

1.24 Ms A was discharged from the hospital on 4 May 2017. The risk formulation in her discharge summary is weak. The details of Ms A's actions leading up to, and after, her admission have become less clear and there is too much emphasis on how Ms A appeared at the time of writing. The risk formulation does not give an accurate impression of what had happened in the preceding weeks or the on-going risk that Ms A posed. Staff who saw Ms A unwell during her admission told us that they were clear about the severity of her condition. This clarity does not carry through in the notes, however, and so it was harder for subsequent professionals to get a clear idea of her condition.

1.25 Our expert told us that he believes that a simple summary of Ms A's condition could have been made after her admission in 2017:

- When her mental health deteriorates the risks that she poses, principally to others but also to herself, increase significantly and seriously
- She has a history of ambivalence around medication and can present as guarded – these are further risk factors
- Medication is effective, so her risk can be reduced if compliance is ensured by administering medication via depot and managing side-effects.

1.26 Although all this was known, our expert does not believe that this comes through clearly in the notes.

1.27 The notes that we have seen contain a lot of information – some of it very useful, other parts less so. There were a few essential facts which it would have been useful to have in the forefront of the mind when treating Ms A. These facts - and the essential risk factors - are hard to find in the notes. They are not gathered together in a single risk formulation and are not highlighted for the unavoidable attention of those treating and supporting Ms A.

Community Treatment Order

1.28 Ms A was discharged on a Community Treatment Order (CTO). A CTO attaches conditions for the treatment of a patient in the community and provides the right to recall the patient to hospital for immediate treatment if necessary. In this case, the order for Ms A required her to take her medication as prescribed. She was also required to make herself available to her care co-ordinator and attend out-patient appointments. Ms A was put on the CTO because of the risk that she presented when untreated and the difficulties with her taking her medication while she was in hospital.

1.29 While in operation, the Community Treatment Order worked effectively. It was renewed in October 2017 and continued until May 2018. By that time, as Ms A was well and co-operating with treatment, there would have been few legal grounds for keeping the CTO in place. There is every good reason to think Ms A would have been discharged from the CTO if she had challenged its legality at a Mental Health Tribunal.

1.30 However, it is important to note that Ms A was reasonably well at this time because she was taking her medication. When she did not take her medication, she became seriously unwell and potentially dangerous. Maintaining her good health was therefore crucial.

Handover from the Early Intervention Team to the Community Mental Health Team

1.31 Ms A was transferred from the EIT to the CMHT in December 2018. This is a normal process. The EIT's role is to bring services together for a period of time after a person's first episode of psychosis. This approach taken is in line with national guidance. The care provided by the CMHT is generally less intensive than that provided by the EIT. Her care co-ordinator in the EIT had established a good relationship with Ms A and knew her well. Moving Ms A between teams therefore created some additional risk as some relapse signs were subtle and difficult to pick up for someone coming new to her case. However, at this point Ms A had been well for some time and had asked to go back onto depot medication of her own initiative. Without the benefit of hindsight, therefore, it is difficult see what other approach the trust could or should have taken.

1.32 Although Ms A's care co-ordinator in the EIT gave the new care co-ordinator a detailed and thorough picture of Ms A when she was ill, the handover took place orally and is not recorded in detail in the notes. This means that when the new consultant psychiatrist

subsequently accessed Ms A's notes, he was not able to see what had been said in the handover.

Change of medication – August 2019

1.33 As we have noted, Ms A's medication changed a number of times over the years. An important change came in August 2019 when she moved from receiving her medication by injection and returned to oral medication. The decision was important because it is much easier to monitor whether a patient is medicated if they are given an injection that lasts weeks or months than if they are taking medication every day.

1.34 Her consultant psychiatrist told us that she was adamant that she didn't want the injections any more. He noted that Ms A had mental capacity, was an informal patient and no Community Treatment Order was in place, so he did not have any formal powers to compel her. However, Ms A's care co-ordinator was not consulted and did not agree with the decision to change the medication.

1.35 Our expert told us that the consultant psychiatrist could have been more assertive and put off making an immediate decision. Our expert pointed out that the level of risk associated with this decision was not clearly set out on the record and it is not certain that the risk this decision involved was properly understood. It would have been better if the consultant psychiatrist had taken more time over this decision and consulted with the care co-ordinator who had greater knowledge of the details of Ms A's history. The history of Ms A's medication changes suggests that she was willing to take advice as to how best to change from one medication to another, and it seems at least possible that if the psychiatrist had suggested setting up another meeting to include the care co-ordinator, she would have agreed. Of course, the outcome of such a meeting cannot be assumed.

Treatment in late 2019

1.36 The care co-ordinator initially increased her contact with Ms A after the change of medication. On occasion, Ms A actively asked for additional supplies of her medication, which gave the team re-assurance that she was complying with it. While the trust had

systems in place for dealing with patients who were perceived to be high risk, at this point, Ms A was simply not seen as being a high-risk patient.

Treatment in 2020

1.37 Ms A's care co-ordinator had to go on sick leave for a month from 21 January 2020. She told us that her normal practice in these circumstances would be to focus on handing over to colleagues people who were rated as high risk. Ms A did not fall into this category. Ms A had a few interactions with the trust in the absence of her care co-ordinator, although she called the trust to ask about her prescription on 22 January 2020.

1.38 The care co-ordinator came back from sick leave on 24 February 2020. She contacted Ms A on 9 March 2020 and saw her on 11 March 2020. The care co-ordinator went on holiday the following day and did not write up the notes of the meeting until after she came back. That was after the attack on 22 March. That is clearly not good practice. The care co-ordinator said that she had prioritised writing up the notes of those patients that she was most worried about so that colleagues would have the most up to date information about those patients.

1.39 The notes the care co-ordinator subsequently wrote describe Ms A as being "*calm and settled*". The care co-ordinator recalls sitting on the bed next to Ms A and "*chatting*". She says that she didn't have concerns about Ms A at that point. Although the note was written up after the attack, it is consistent with notes the care co-ordinator wrote after visits in the previous months.

1.40 A few days after the meeting with Care Co-ordinator 3 on 11 March 2020, a member of Ms A's family went to stay with her. The family member told us that when she arrived she knew that Ms A was unwell. She says that she saw her cutting the medication in half. Ms A confirmed that in the weeks before the incident she started to take only half of her prescription because of the side-effects of the medication. We do not believe that anyone in the trust was aware of this.

1.41 Our expert told us told us that it is common for mental health patients not to take their medicine regularly – research shows that this can happen in 50 per cent of patients. If they are not taking their medication, our expert told us that a patient "*can take a long time*

to deteriorate abruptly". He thought that this is why it is so important for the clinical team to be aware of the early relapse indicators or '*low grade*' symptoms.

After the incident

1.42 Whilst in custody, Ms A was described as calm and generally co-operative. The report of the Mental Health Act interview carried out at the police station on the evening of the incident described her as suspicious and guarded, but also composed and coherent.

1.43 Ms A was subsequently sent to a high security hospital. Our expert spoke to Ms A's current responsible clinician there. Our expert summarised what had been learnt as follows:

- Ms A can present with only 'low-grade' symptoms for some time (6 – 8 weeks) when non-compliant with medication before she then becomes overtly psychotic more abruptly
- The more overt and irritable aspects of her psychosis respond to reasonably low doses of antipsychotic drugs
- These 'low grade' symptoms are difficult to pick up on, particularly due to Ms A's English, but are certainly precursors to more florid illness and significantly greater risk.
- Ms A is sensitive to the side-effects of antipsychotic medication know as 'extra-pyramidal' (that may include spasms, muscle contractions, irregular jerky movements or symptoms similar to Parkinson's disease), but if the dose is increased slowly she can tolerate reasonably high doses without issues.

Overall comment

1.44 Taking the evidence from the incidents described here and that from the team in the high security hospital together, our expert believes that it is understandable that signs of a relapse were not evident to the care co-ordinator when she met Ms A on 11 March 2020. To do so would have required the care co-ordinator to engage in a detailed mental state examination. Our expert noted that Ms A always presented as guarded, so that in itself would not have been sufficient to conclude that Ms A was on the point of relapsing. It is also significant that Ms A's change to being psychotic and more overtly irritable and risky

can be abrupt. In these circumstances it would not be appropriate to criticise the care co-ordinator.

Commentary and analysis

Care and treatment

1.45 We are asked to identify any "*gaps, deficiencies or omissions*" in Ms A's care and treatment.

1.46 Ms A's medication history is characterised by an oscillation between a range of different prescriptions. The evidence suggests that the trust may not have got the balance of medication right. Compliance with medication for chronic conditions is often poor. Ms A was even less likely to be compliant if:

- Medication gave her significant side-effects
- The medication did not relieve all her psychological distress; and
- Her insight fluctuated.

1.47 Yet Ms A's continued compliance with medication was a crucial factor in mitigating the risks that she posed on account of her mental disorder. Carefully balancing a gradual increase in depot medication combined with robust treatment for side-effects (as has now been done successfully) might have been more effective and therefore had a better rate of compliance. We accept that this is a much harder task in the community than in a hospital setting.

1.48 It is important to note that the care provided to Ms A took place within a legal context and also the context of the NHS's general approach to care. People with mental health disorders are generally free to accept or reject medical treatment in the same way as people with physical health disorders. It is only in some, strictly limited, circumstances, that people with mental health disorders can be required to accept some treatments, including medication. Where the individual and their doctor have different views about treatment, it is crucially important to understand the available options, including the possible option of compulsory treatment. Accurate risk assessment is a necessary part of the complex decision on what is legally possible, what is the least restrictive option, and what is most likely to lead to recovery and sustained good health.

Risk assessment and management

1.49 Ms A's records provide examples of good practice in the day-to-day management of risk. They also show that the clinical risk management process was working, with early warning signs discussed and changes made to medication as a result.

1.50 However, there are problems with the way risk was described by the trust. There are instances where the risk Ms A posed was measured in terms of how she presented at the particular time the assessment was being carried out, rather a more longitudinal view of her overall risk being taken.

1.51 It was clear by 2017 that Ms A presented risks to others when she was ill, but not when she was well. It was also clear that she became unwell when she was not taking medication as prescribed.

1.52 The key risk – that she is dangerous when unwell – is a fixed risk which does not change over time. It is possible that the risk of her becoming unwell changed over time, but in fact the key determinant there was medication. A period of time when she was taking effective medication, therefore, did not provide any evidence of a change in this fixed risk.

Recording of risk

1.53 The trust's risk policy makes a distinction between "*previous*" or "*past*" risks and "*current*" risks. It doesn't explain the significance of the distinction between the two. Although it refers to "*static factors*" and "*dynamic factors*", the policy does not make any comment on how they interact. It would not be surprising if readers of the policy were left with the idea that the passage of time was a key factor in assessing risks and that things that happened some time ago are only evidence of past or previous risks.

1.54 Similarly, the trust's standard paperwork makes the person carrying out an evaluation distinguish between "*current*" risks and "*past*" risks, with the cut off between them being 14 days. The distinction between something that happened 13 days ago being

'current', and one happening 15 days ago being a 'past' risk is arbitrary and potentially misleading.

1.55 The series of tick-boxes in the trust's documentation is also unhelpful as it reduces the reporting of complex issues to arbitrary and narrow categories.

1.56 The trust's risk paperwork is unhelpful in other ways. While there are sections asking for an overview of risks and action to be taken, these are hidden in a mass of other questions and boxes. At best these other sections tend to obscure the important information, at worse, they mislead the author into making false distinctions and to think about risk in an unhelpful way. The use of red, amber and green ratings is also confusing as it does not appear to match the use of the same terms used by the trust in internal meetings.

1.57 The risk assessment form should be re-written, so it begins with a brief, unambiguous, risk formulation of the key information the reader needs to know about the patient. This would also provide a prompt for the reader to look in more detail at relevant aspects of the case.

1.58 In Ms A's case, what the reader needed to know can be reduced to a handful of words: never completely symptom free; always guarded; dangerously delusional when acutely unwell; becomes ill when unmedicated; relapses into acute illness without much warning; uses weapons when acutely ill.

1.59 The essentials can be put even more starkly: dangerous when unwell; unwell when unmedicated. The documentation failed to make this clear.

Safeguarding

1.60 The concept of safeguarding is based around there being particular groups in society who are at risk from others, whether that is because they are children, infirm or vulnerable in some other way. Ms A's second episode of absconding did result in a safeguarding referral, but it was not considered to be a significant risk by the safeguarding team because Ms A was back in hospital and detained when the referral was made.

1.61 Ms A's risk arose from the paranoid identification of particular others as a danger to herself. But Ms A was a danger in general when unwell. The vulnerability of her victim did not alter that. In practical terms, the key question in this case is whether anything would have been handled differently if it had been identified as a safeguarding matter. We do not believe that is so.

The trust's internal investigation

1.62 The trust's internal report was completed and approved on 20 October 2020. The report was produced by a team of three staff at the trust. The terms of reference provided were very detailed. In particular they included approximately 30 tasks for the team to complete. These were used as the key lines of inquiry for the internal investigation. While these in themselves covered sensible areas, the sheer number of them encouraged a 'tick box' approach, rather than standing back, reviewing the evidence and determining which areas should be focused on. Not all of the tasks identified were fully addressed in the investigation report.

1.63 The report is fairly comprehensive in setting out the facts and addressing the main issues in the case. However, it is weaker when it comes to analysis. The terms of reference ask specific questions about the adequacy of what staff did, but there is little analysis of the actions in terms of what should have been done or might have been done differently. Conclusions are not drawn about how well things were done.

1.64 The report says that from the information available "*it would appear that there was no indication either to the mental health team or to the family that Ms A's mental state was deteriorating and therefore, it is difficult to see how this incident could have been prevented*". This is a broad conclusion to reach. We do not believe that the report provides sufficient analysis to justify this conclusion.

Conclusions and recommendations

1.65 Our expert has summarised Ms A's case as follows:

- The risks when Ms A's mental health deteriorates are significant
- Ms A had a history of ambivalence around medication – this further increased the risk, which was particularly significant when she was taking oral medication
- These issues could best be dealt with by trying to ensure that Ms A agreed to, and accepted, depot medication (i.e. by injection)
- The depot needs to be carefully prescribed, with anti-side-effect medication, for maximum effectiveness.

1.66 Our expert believes that this should have been clear after the incidents in 2017, if not 2015.

1.67 There are a number of areas where the trust could learn from this case. We believe that this learning may have lessons for other trusts across the country.

1.68 Our most important finding is that the trust's understanding of risk concepts was poor. While there were good examples of practical decision-making around risk and medication, the overall risk that Ms A posed was not given sufficient weight. When Ms A's mental health worsened, there were significant risks. The trusts policy and documentation, and the way that it was interpreted by some staff, placed too much emphasis on how a service user presented on any given day, rather than their underlying risk profile. This focus on the 'weather rather than the climate' was at the heart of the trust's failure to properly understand the unchanging risk that Ms A posed.

1.69 Another important finding is in relation to the documentation of risk. Our expert's summary of Ms A's case is a little more than 50 words, but it gives any reader the essentials of what they need to know. Even a close reading of the trust's eight-page risk assessment form would provide less information than this – and it would take many hours of studying Ms A's extensive clinical records to get the same understanding. A way must be found for this sort of summary to be prominently displayed at the top of clinical records. If good examples of this being done in other trusts are not available, NHS England should review how it can be done.

1.70 We recognise that there are a number of constraints operating on the trust and its staff. These include:

- The legal framework in which it operates

- Financial pressures that mean that care co-ordinators and consultant psychiatrists work under high pressure with large workloads
- Practicalities – that options for dealing with service users who do not engage with staff are limited.

1.71 Nevertheless, it is vital that staff ensure that they have the facts of each case and record them properly. There are examples here, particularly with regards to events in 2017, where there was a lack of curiosity so that the trust never got to the bottom of what happened.

1.72 Furthermore, there were times when it was evident that the trust had not fully 'bottomed out' clinical aspects of the case – in particular in relation to Ms A's medication where there was an oscillation between controlling her symptoms and addressing the side-effects that she suffered. A number of people have pointed out that a forensic examination of Ms A's case in 2017 would have been useful. We accept that this is easy to say with hindsight, but in the circumstances of a serious threat of violence and the lack of effective treatment, a forensic referral should have been attempted.

1.73 We welcome the trust's moves to use zoning and multi-disciplinary meetings more effectively so that staff can provide each other both with greater challenge and support. We believe that an open, inquisitive culture would have improved the likelihood that more imaginative steps in handling Ms A's care could have been taken.

1.74 Finally, we would like to note that many staff we spoke to were very aware of the tragic circumstances of this case. Many are personally devastated that they were not able to prevent the terrible outcome to Ms A's treatment by the trust and wanted to pass on their commiserations to the victim's family. Ultimately, only Ms A herself bears responsibility for what happened, but we are sure that trust staff are fully committed to the changes in systems and processes which to reduce the risk of events such as this occurring in future.

Recommendations

1.75 The following are our recommendations. We believe that the trust is best placed to determine an appropriate timescale for their implementation in conjunction with NHS England.

R1 The trust should review its risk policy to ensure that static risks are identified, and realistically assessed, and unnecessary weight is not given to dynamic factors.

R2 When the trust has updated its risk policy, it should ensure that staff have a clear understanding of how to assess risk accurately.

R3 The trust should ensure that a concise summary of the risks of each patient to themselves and others is prominently displayed on the patient record.

R4 If there are not good examples of other trusts displaying concise summaries of risks prominently on patient records, NHS England should examine how it can support trusts to do this.

R5 The trust should continue to review zoning and multi-disciplinary team meetings to ensure that they promote a positive discursive atmosphere where staff challenge and support each other.