An independent investigation into the care and treatment of Mr E by Greater Manchester Mental Health NHS Foundation Trust

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Sancus Solutions wish to thank the families of Mr R and Mr E for their involvement with this investigation. Their generous contributions have been of great assistance in enabling a deeper understanding of the events that led up to this tragic incident.

It is Sancus Solutions sincere wish that this report does not contribute further to their distress and provides some answers to their questions.

Sancus Solutions' investigation team would also like to acknowledge the contribution and support from both Greater Manchester Mental Health Foundation Trust's staff and the other involved health and care services.

Contents

1 Executive summary

The incident

Mr E[1], aged 32 years, pleaded guilty to the manslaughter of his cousin Mr R [2]on the grounds of diminished responsibility. He is currently an inpatient at a high secure hospital under Section 37/41 of the Mental Health Act 1983.[3]

Mr R's family reported to Sancus Solutions' investigation team (hereafter referred to as the investigation team) that following the death of Mr E's mother in October 2019, Mr R, his cousin, became increasingly the most significant and ongoing source of support for Mr E.

Commissioning of the investigation

The incident that resulted in the death of Mr R met the following criteria for the commissioning of an independent investigation under NHS England Serious Incident Framework:[4]

"When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach (CPA) or is under the care of specialist mental health services, within the 6 months prior to the event."[5]

In July 2021, NHS England commissioned Sancus Solutions[6] to undertake this investigation. Unfortunately, due to some significant difficulties in obtaining access to Mr E's Primary Care records, the investigation did not commence until February 2022.

Involvement of Mr E, his family and Mr R's extended family

The Terms of Reference asked the investigation to:

"Ensure that affected family members are informed of the investigation, the reviewing process and are offered the opportunity to contribute to this process including developing the terms of reference; agree how updates on progress will be communicated including timescales and format."[7]

[1] Mr E is a pseudonym.
[2] Initial have been agreed with Mr R's family
[3] Section 37/41
[4] NHS Serious Incident
[5] NHS Serious Incident p47
[6] Sancus Solutions
[7] ToR p2

The investigation team had virtual meetings with:

- Mr R's wife, members of his extended family and their advocate.
- Mr E and members of his family.

Mr E's mental health

In adulthood Mr E had the following a mental health diagnosis:

- Paranoid Schizophrenia[8]
- Psychopathic Personality Disorder[9]

It was assessed that Mr E had an atypical presentation of his mental health illness, which presented with episodic rapid and acute onset of psychotic symptoms which generally occurred between the months of January to March. There were two significant precipitating factors to these episodes, namely that Mr E became non-compliant with his antipsychotic medication, olanzapine,[10] and he disengaged from mental health services.

In March 2019: following an incident where Mr E attacked and seriously injured his grandfather, he was detained under a Section 2 of the Mental Health Act 1983[11]. On his discharge he was initially supported by Greater Manchester Mental Health NHS Foundation Trust (hereafter referred to as the Trust) Home Based Treatment Team (HBTT) and then transferred to North Community Mental Health Service[12] (hereafter referred to as CMHT) outpatient services.

Chronology of events

Date/time	Event	Comments
26/02/20	Mr R took Mr E to the GP, where he reported his concern about the deterioration in Mr E's mental health and non-compliance with his medication. The GP prescribed olanzapine[13] 5mg.	
27/02/20 3am	Mr E kicked in the door of his ex-father-in-law's house. His ex-father-in-law hid in the back of the house.	

[8] Patient records 25 March 2020
[9] Patient records 20 March 2019 12.37pm
[10] Olanzapine
[11] Section 2 of the Mental Health Act 1983 – criteria are that a person is potentially suffering from a mental disorder of a nature/degree that warrants their detention in the interests of their safety and/or the protection of others. Compulsory admission can last up to 28 days. Section 2
[12] Community Mental Health Service
[13] Olanzapine

27/02/20 9am (approx.)	A member of the family contacted the police to report that she had viewed the CCTV footage and it showed Mr E causing criminal damage to her father's property. She also reported that Mr R was Mr E's main carer, she was concerned about Mr E's current mental health and non-compliance with his medication.	
27/02/20 9a.m. (approx.)	- The medical secretary to CMHT's psychiatrist reported that when she arrived at work, she noticed that she had multiple missed calls and a voicemail message from Mr R. - The medical secretary reported that she rang Mr R, who explained his concerns about Mr E. She gave him the direct telephone number for the CMHT's duty team. - On his arrival into the office Mr E's previous care coordinator reported to CMHT's duty team that he had received a text message from Mr E, which had been sent at 8.33am on 26 February. The text stated: 'here give us a buzz matey Regards [Mr E].' - 10:58: the medical secretary sent an email to the CMHT's team manager and psychiatrist reporting Mr R's concerns about Mr E. - CMHT's team manager emailed the consultant psychiatrists reporting that the duty team were going to visit Mr E to carry out an assessment. She also inquired if there was capacity at the clinic the following day to assess Mr E. - Later in the day, Mr R again telephoned the medical secretary. She recalled that Mr R sounded genuinely concerned about Mr E. He reported that Mr E was making threats towards his ex-father-in-law and that he had caused some criminal damage to his property the previous evening. She recalled asking Mr R "if he felt safe." The medical secretary reported that she had telephoned the CMHT's	There were some differing accounts of the timing of the events. It was during this interaction that the duty team identified that Mr E did not have an allocated care coordinator.

	manager and also the duty desk to report Mr R's concerns. - Mr R rang the CMHT duty desk and reported his concerns about Mr E and the recent events and the deterioration in his mental health. He also reported that Mr E had told him that he had stopped taking his medication 8 weeks ago and that he was becoming increasingly agitated and expressing delusional thoughts. - The CMHT on-call duty practitioner informed Mr R that the decision had been made to go and assess Mr E and that it might result in Mr E being either admitted to hospital or referred to the home-based treatment team (HBTT) and/or CMHT. It was noted that Mr R agreed with this plan. - The duty team emailed the CMHT's on-call doctor and consultant psychiatrist to ask for advice. The on-call doctor advised that they should encourage Mr E to be concordant with his olanzapine. - Two members of the duty team went to Mr E's house, but he was not at home. Phone contact was then made with Mr E. It was reported that Mr E answered the call and reported he was at a shopping centre. - It was explained to Mr E that Mr R had contacted them to express his concerns about his mental health. Mr E agreed to a meeting with one of the duty team the following morning at his home. It was agreed that the duty team member would assess Mr E's risks the following morning and dependant on the risks identified he might be placed on the CMHT's Red Zone until he was stabilised on his olanzapine.	It was documented that Mr E sounded calm and responded appropriately to the concerns reported and the future involvement of the CMHT.

	- It was documented that one of the visiting duty workers would be Mr E's allocated care coordinator. - It was noted that Mr E 'sounded settled' and an outpatient appointment was arranged for 28 February 2020. - A STAR v2 risk assessment was completed by one of the visiting duty workers. - Mr E phoned the police and told them that he was standing over someone holding an axe.	The exact time of phone call was not known.
28/02/20	- 00:12 approx. Mr E was arrested for the murder of Mr R.	

Findings and analysis

The Terms of Reference asked Sancus Solutions to:

"Analyse the patient's records to undertake a critical review of the care, treatment and services provided by the NHS, reviewing significant events and contact with services two years prior to the time of the offence.

Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern."[14]

This section provides a very brief summary of the investigation's findings and analysis.

Risk assessments and risk management

The review of Mr E's patient records revealed that risk information and risk assessments were being documented in multiple sites, for example Mental Health Assessment tool, CPA assessments and reviews section - 'My relapse and Crisis Plan,' Mental Health Clustering Tool, progress notes and Standard Tool for the Assessment of Risk (hereafter referred to as STAR V2)[15]

[14] ToR p2

[15] The STAR is made up of 20 dynamic items relevant to treatment and risk management, such as substance use, mental state, social skills and coping, among others. Each item is rated as both a vulnerability and a strength. STAR

The Trust reported that the STAR V2 is where risks are assessed and documented and is where a complete record of all known or suspected risks should be documented.

The investigation team concluded that there were some significant disadvantages of risk information being located in multiple sites: for example, risk information can get overlooked and it can be time consuming to review multiple assessments and the focus/purpose of a particular risk assessment can become diluted.

The investigation team had considerable concerns that within the various assessments that were undertaken, the content and the ongoing identification and assessments of Mr E's risks, particularly with regards to his risk to others, did not adequately reflect and/or assess either his historic or more recent risk incidents. For example:

- March 2019 Mr E had made an apparent unprovoked attack on his elderly grandfather, which caused a significant head injury, and resulted in a Restraining Order and police investigation.

- Mr E had, on a number of occasions, attacked members of A&E Department staff.

- Mr E was on the Sex Offenders Register, he was a convicted perpetrator of domestic violence and had intimidated a witness who was also the victim.

- Despite a Restraining Order being in place Mr E was reporting that it was his intention to have unsupervised access to his children. Mr E's mother disclosed that he was breaching his Restraining Order.

- Prior to her death Mr E's mother disclosed that her son had made threats to harm her and a female friend and that he had been in possession of a knife when he made these threats.

- Due to his work Mr E had access to potentially dangerous tools.

There was little consideration of the possibility that Mr E's suspected substance misuse problem needed to be risk assessed in order to develop an accurate picture of how it may have been contributing to his mental health presentation and risk factors.

Additionally, it was evident that the risk assessments and risk management plans that were undertaken were based mainly on Mr E's self-reporting. The Clinical Risk Policy warned assessors that although:

"self-reporting by the service user is very important, [it] should not be relied upon alone, particularly if risk to children is being considered. The accuracy of information and the amount of emphasis that should be placed on the information available will need to be considered and documented in clinical records."[16]

There was no evidence that the assessors considered the reliability of the information obtained from either Mr E's self-reporting, nor did they seek to validate information from either other involved agencies or his family.

The CMHT's practitioners, who had assessed and supported Mr E, reported that he was always eloquent, in both his appearance and presentation. He reported that he ran a successful business, and he also gave the impression that he had considerable insight into his mental health. He was also able to identify what actions he needed to take to remain well, which included his ongoing compliance with his medication regime and engagement with mental health services. It was reported that based on this presentation he was not viewed as a high-risk patient that required on going intensive monitoring; or that further information/details were needed about either his Restraining Order or Sex Offending Register.

It was reported that at the time there were a combination of significant human and resource factors that resulted in the CMHT being a service that was under immense pressure. The investigation team noted that some members of the team were inexperienced, and the use of agency staff was high. It was reported that one of the many issues that the services were having to manage was not only supporting existing patients, many of whom had significant risks, but also having to be responsive and accept all referrals who were assessed as having reached the service's threshold. It was also reported that, at the time, case numbers were, and continue to be, very high, and that the care coordinators and senior managements' daily focus continues to be on crisis referrals and management. It was recognised that this can result in care coordinators not having the capacity to focus on patients, such as Mr E, who appear to be functioning well, their mental health was stable and who have family to support them. It was also recognised that this can lead to certain patients, such as Mr E, who have high risk histories, being overlooked.

It was also reported that the on-going issues at the time resulted in their being no effective and responsive management systems in place that would have identified either that there was no care coordinator allocated to Mr E, or that a more proactive action was required in response to Mr R's concerns.

The investigation team were informed that it was not uncommon for CMHT team managers to be recruited without having extensive experience in managing such a complex service as the CMHT. It was reported there is now intensive senior

[16] Clinical Risk Policy 26 September 2019 p10

management support, supervision, IT systems and meeting structures for the on-going monitoring patients to ensure that they receive on going care coordination, risk assessments and care plans. There is also a management Leadership Programme, which incorporates a Certificate in Leadership endorsed by the Institute of Leadership and Management, available to all service managers.

The investigation team were unable to definitively conclude why Mr E's historic and more recent risk history did not prompt a more accurate risk assessment or management plan to be completed that reflected his risk factors. However, they did conclude that the duty team initial response to Mr R's concerns was a proportionate response. However, given the information and concerns expressed by Mr R combined with Mr E's known risk history, further action should have been taken that evening: for example, to seek management guidance and/or report Mr R's concerns to the police, and request that they undertake a welfare check on Mr E.

Forensic assessment

The investigation team concluded that the lack of a forensic referral and/or assessment being sourced was a significant missed opportunity as it would have enabled a comprehensive collection and assessment of specific forensic risk information, in one comprehensive and combined structure, rather than in disparate assessment tools. Given Mr E's forensic history the investigation team concluded that priority should have been given to involving the Trust's community forensic services, not only to undertake a forensic assessment, such as HCR-20, but also to provide the CMHT with ongoing support in their assessment, management and support of Mr E.

Although the forensic assessment would not have specifically identified Mr R as a potential victim it would have provided essential information about the potential historic and current risks that Mr E was presenting. Particularly with regard to his risks to members of his family, and specifically the more vulnerable members who had previously been victims to unprovoked aggression from Mr E.

A forensic assessment would also have ensured that important and up to date information with regards to Mr E's Restraining Orders and the Sex Offenders Register status, could have been obtained, risk assessed and documented. This information would have then informed Mr E's care plans and risk management plan and would have also encouraged on going multi agency communication. There was no evidence of the CMHT's practitioners seeking information from other involved services, e.g., police, and/or agreeing joint care plans and an information sharing protocol.

Analysis

The investigation team concluded that given Mr E's recent risk history, particularly the risks to members of his family when he disengaged from mental health services and ceased taking his medication, these risks were not adequately risk assessed and/or documented.

Additionally on the night of the incident given the information and concerns reported by Mr R and Mr E's known risk history the investigation team concluded that more pro-active action(s) should have been taken when the duty team failed to see Mr E - for example they should have sought senior management advice and/or reported the situation and the potential risk concerns directly to the police to both share risk information and agree an immediate risks management strategy.

Despite these concerning deficits in the risk assessment and the responses to Mr R's reported concerns the investigation team are unable to definitively conclude that if they had been addressed differently the events that led to the tragic death of Mr R would not have occurred.

The investigation team are not going to make any direct recommendations with regard to improving the Trust, and specifically the CMHTs' risk assessments and risk management, as they have seen evidence of several significant developments that are currently been implemented within the Trust. They are, however, recommending that at Sancus Solution's quality assurance visit the Trust should be in the position to provide evidence of the implementation of the new risk assessment and management processes, specifically within the CMHT service.

Medical secretary

This investigation has highlighted an important issue relating to the reporting and documentation of a medical secretary's contact with Mr R on 27 February 2020.

The investigation team concluded that this issue requires further inquiry by the Trust in order to ascertain if there is a specific learning requirement to ensure that all medical secretaries are aware of where they should be documenting any contact they may have with patient and their families.

Psychological and pharmaceutical therapies

Aside from Mr E's mental health symptoms it was known that he had multiple and complex behavioural and antisocial issues. Given these complexities the investigation team had concerns that it appears that no psychosocial assessments

and/or psychological interventions - such as, behavioural analysis[17], cognitive behaviour therapy (CBT) [18] or dialectical behaviour therapy (DBT[19]) - were ever considered or discussed with Mr E.

It is accepted that given Mr E's degree of denial, with regard to both his current and past mental health issues and offences the investigation team would suggest that engaging him in a recovery-based and/or behavioural therapy would always have been challenging.

With regard to Mr E's medication olanzapine: the investigation team were of the opinion that given his presentation, particularly when he was acutely unwell, was a reasonable choice of medication and the dosage etc met the respective NICE and the prescribing guidelines.

The dispensing of this medication, via a depot injection, was discussed with Mr E, prior to his discharge from the inpatient unit in 2019, but it was documented that he refused to consider this option. As Mr E was not on a Community Treatment Order medication enforcement could not be part of his discharge plan although it was documented that to avoid further relapses Mr E was strongly advised to be compliant with his medication regime.

As Mr E's chronology indicated there was a repeated pattern of behaviours that after his mental health was either stabilised in the community and/or he was discharged from the inpatient unit, he would quickly begin requesting that the medication be reduced and stopped. Regardless of the advice given to Mr E he would stop his medication, without medical supervision, as part of his care plan or it being risk assessed.

It is recognised that most medications have side effects and to encourage on going compliance it is important that a patient and their clinical team try to identify a medication that causes the minimal amount of unwanted negative side effects. It was evident that olanzapine had a significant and positive affect on Mr E's mental health symptoms, but he was repeatedly reporting that he did not like the physical side effects of this medication, such as weight gain. For a person, such as Mr E, where physical fitness was an important part of his identity and also his working life it was, perhaps, inevitable that when he gained weight and as such was likely to stop his medication and then his engagement with services.

[17] Behaviour analysis utilises learning principles to bring about behaviour change. Behavioural analysis
[18] CBT Cognitive behavioural therapy (CBT) is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems. It is a NICE recommended therapy to manage a range of mental health issues. NICE guidelines
[19] DBT

The investigation team were unable to locate any documented evidence that an alternative medication regime was ever discussed with Mr E, specifically a medication that would not have these particular adverse side effects. This, the investigation team would suggest, was an error and resulted in Mr E, yet again, stopping his medication, without medical supervision and disengaging from the CMHT. As on previous occasions Mr E's mental health then rapidly deteriorated, his risks increased, and, on this occasion, it was the most significant causal factor in the catastrophic event that led to the death of Mr R.

Safeguarding

At the time of Mr E's involvement, the CMHT services' safeguarding information and associated assessments were documented in a patient's CPA and STAR V2 assessment forms. The investigation team noted that despite the numerous known possible safeguarding issues, with regard to Mr E and his family (including elderly and vulnerable adults, women and children) there was no documented evidence of the involved Trust's practitioners or services considering/responding to possible safeguarding concerns or reporting the information via their agencies' safeguarding pathways.

The Trust's Safeguarding Adults Policy clearly outlines the safeguarding responsibilities and actions of all its staff, are required to take where there is a reported and/or suspected safeguarding concern and/or an incident. The policy states that it is designed to ensure:

"strong multiagency partnerships working together with adults to prevent abuse and neglect where possible and provides a consistent approach when responding to safeguarding concerns. This entails joint accountability for the management of risk, timely information sharing, co-operation and a collegiate approach that respects boundaries and confidentiality within legal frameworks."[20]

The policy provides clear procedures/actions for its staff where there are known or suspected safeguarding concerns.

There was no evidence that either the Trust and Local Authority' adult/children safeguarding, or children's Social Care Services were contacted to provide advice and/or to raise a safeguarding alert. This, the investigation team, concluded was a significant error. Additionally, it was noted that in Mr E's care plans that his contact with his children was identified as being his protective factor, there was no apparent inquiry, assessment or concern raised by the involved practitioners, about the recent incidents of violence against members of his family that resulted in two Restraining Orders. The investigation team would have expected that rather than

[20] Safeguarding Adults Policy p6

Mr E's family, especially his children, be identified /assessed as protective factors, and, at the very least, advice should have been sought by the involved practitioners as to whether any safeguarding action was required.

In conclusion the investigation team were not satisfied by the response to potential safeguarding issues and would suggest that it has highlighted deficits in the CMHT teams' underdoing with regards to their safeguarding responsibilities in this case. The investigation team is therefore recommending that as part of the ongoing learning from this case that the CMHT have specific service safeguarding training.

Carers' involvement and support

Despite the Trust's commitment to the six key principles of the Triangle of Care[21] and carers assessments and involvement being key components in numerous Trust's policies and guidance there was no evidence that Mr E's mother, Mr R or any other members of the family, were involved in any of Mr E's assessments or care/risk plans. Nor was there any evidence that they were provided with information about either the Trust's carers support services, so that their support needs and potential risk could have been assessed, and/or signposted to other agencies' carers services.

This lack of carers support and involvement was of concern to the investigation team, as the importance of involving families and carers has, for many years, been one of the cornerstones of multiple key public health strategies. For example, the government's cross-party outcomes strategy No Health Without Mental Health (2011)[22] recognised the importance of carers and families and the significant "serious and long-lasting impact on the quality of lives of individuals, their families and carers"[23]. It also emphasises the Trust's statutory obligation and importance of "putting families and carers, at the centre of their care … enabling them to have choice and control over their lives and the services they receive"[24].

The Trust's Serious Incident Report (hereafter referred to as SIR) also highlighted, as a specific area of learning, the need for significant improvement in the involvement and support of families.

As with the deficits highlighted in relation to risk assessments, the investigation team were satisfied that the SIR's recommendation adequately seeks improvement and remedial action to improve and encourage family involvement. They will therefore not be making any specific recommendations but will seek to review the Trust's progress at their quality assurance review.

[21] Triangle of Care
[22] No Health Without Mental Health
[23] No Health Without Mental Health
[24] No Health Without Mental Health

Service and operational developments

During the course of this investigation, it was apparent that in response to the findings and recommendations of the SIR, and/or as part of the Trust's ongoing Transformation Plan[25], there have been a number of significant developments that either have been fully implemented or are currently in the process of being implemented.

One of the results of the Trust's ongoing Transformation Plan[26] has been:

"The transformation of services in line with the Mental Health Improvement (MHIP) Programme/specifications, and place-based care … Provision of a seamless urgent care pathway between inpatient services and the CMHTs … to ensure a rapid effective intervention responsive to service users' needs, including the capacity for increased support … CMHTs are aligned to the neighbourhood model of the Manchester Local Care Organisation."[27]

The Transformation Plan has implemented an Enhanced Community Model, which aims to make "community services more accessible and simpler to navigate for those who use them"[28].

One of the tools that has been introduced to services is a Management and Supervision Tool (MaST), which aims to "reduce mental health crisis happening … [and enable] more proactive rather than reactive crisis management, [improve] service user flow, and free up resources for other people"[29].

It was evident that as well as managing individual case management MaST enables a more proactive rather than reactive crisis management, improves service user flow and allows for more accurate resource/capacity management.

The investigation team were also provided with the CMHT's revised Service Operation Policy (hereafter referred to as SOP) that was introduced in March 2019. Briefly the SOP outlines:

- the CMHT's service pathway

[25] Transformation Plan
[26] In January 2017 there was a merger of Manchester Mental Health and Social Care Trust and Greater Manchester West Mental Health NHS Foundation Trust. Since the merger, a Transformation Plan has begun to be implemented.
[27] Transformation Plan pp8-9
[28] Transformation Plan
[29] Action plan p3

- function of daily multidisciplinary team (MDT) meetings
- the assessment, monitoring and escalation of concerns and risks
- the structure for the ongoing assessments and management of patients who either need to step down or up “to a higher or lower zone and/or transfers”[30].

As the SOP was ratified and introduced in March 2019, the investigation team would suggest that it should have been fully embedded by November/December 2019, when it was known that Mr E’s care coordinator was leaving. The investigation team were unable to ascertain any systemic issue that explains why this did not occur therefore one can only assume that it was due to a human error, which involved a number of practitioners and the team manager.

The investigation team also were provided with evidence of additional management and auditing structures that have been introduced since this incident. These that provide ongoing processes that are in place to monitor both CMHT services and individual users’ care and risk assessments/pathways.

Since these incidents, the Trust has developed Specialist Community Forensic Teams (SCFTs) within the Forensic Outreach Liaison (FOL) service. Their roles include providing support/advice to services regarding their management of service users who have:

- a forensic history that includes serious violence against others
- a history of substance misuse that has a significant impact on the person’s risk to others.

The service provides:

- advice
- specialist forensic assessment such as HCR-20
- forensic risk formulation.

Clearly this service would have been extremely relevant in the assessment and ongoing management of Mr E.

[30] MDT agenda

Post incident and duty of candour[31]

The investigation team concluded that the SIR was extremely comprehensive and addressed both the reported family's concerns/ questions and ToR. The investigation team also concluded that the report could have benefitted from an improved layout, as, at times, it was difficult to ascertain what was evidence, the voice and/or the conclusions reached by the authors.

It was very evident to the investigation team that Mr R's family's questions and concerns were very clearly documented within the SIR. It was also evident that throughout the SIR process the author has spent time with Mr R's family to ensure that they have been supported through, what has been for them an extremely complex and unfamiliar process.

The investigation team concluded that the Trust met its Duty of Candour with regard to the support and involvement provided to Mr R's family by the SIR's lead investigator. It was reported that Mr R's family have been actively involved in some of the learning events, and also participated in a video where they talked about their experiences. This video had been played at some of the learning events that focuses on this incident. All the practitioners who attended the learning events reported that although it was difficult, it had been a very powerful and important experience/impact. It was also apparent to the investigation team that this was a beneficial experience for members of Mr R's family.

Concluding comments

This was clearly a tragic event which continues to deeply affect the lives of all those involved. The investigation team would again like to express their condolences and thanks to both Mr R's and Mr E's families who generously and graciously agreed to be part of this investigation. It is the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide, at least some, answers to their questions and concerns.

One of the main aims of these investigations that are commissioned by NHS England, is to facilitate a learning environment to improve the future delivery of services and patient safety. Although the investigation team are not suggesting that any one individual practitioner was directly responsible for this tragic event. There were, however, clearly some deficits that have been highlighted in the on-going

[31] 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

assessments and responses to Mr E's on-going risks factors and also in the response to Mr R's reported concerns on 27 February 2020.

The investigation also concluded that the evidence indicated that the last time Mr E was seen by the CMHT team, prior to February 2020, he was not presenting with high enough risks factors, to either himself and/or others, to have warranted either depriving him of his liberty and/or enforcing a particular pharmaceutical therapy, via the use of the powers of the Mental Health Act 1983.

Sancus Solutions' investigation team hope that the findings and recommendations of this investigation will contribute to the learning and development of all the involved services and improve practices.

Recommendations

Recommendation 1: At Sancus Solutions' quality assurance review, the Trust should have evidence of at least one CMHT piloted scheme of the implementation of the revised risk assessment and management processes.

Recommendation 2: The Trust should clarify how medical secretaries are required to record any contact they have with families and patients.

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

Recommendation 3: The Trust should undertake a review of how the CMHT assess and support patients where substance misuse is an identified risks factor.

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

Recommendation 4: The CMHT's practitioners should have additional specific safeguarding training relating to the findings of Sancus Solutions and the Serious Incident Report.

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

Recommendation 5 The Trust should be able to provide evidence of improvements within the Community Mental Health Team regarding family involvement and support at Sancus Solution's Quality Assurance Review.

2 Introduction

The incident

2.1 Mr E[32], aged 32 years, pleaded guilty to the manslaughter of his cousin Mr R on the grounds of diminished responsibility. He is currently an inpatient at a high secure hospital under Section 37/41 of the Mental Health Act 1983.[33]

2.2 At the time of the incident, Mr E was a patient of Greater Manchester Mental Health NHS Foundation Trust's North Community Mental Health Service[34] (hereafter referred to as CMHT).

2.3 Mr R's family reported to Sancus Solutions' investigation team (hereafter referred to as the investigation team) that following the death of Mr E's mother in October 2019, Mr R became increasingly the most significant and ongoing source of support for Mr E. It was documented, in Mr E's patient records, that Mr R attended outpatient appointments with Mr E and on the day before his death he had alerted the CMHT's duty desk of his concerns with regard to the significant deterioration in Mr E's mental health and recent non-compliance with his medication olanzapine.

Mental health diagnosis

2.4 In adulthood Mr E had a mental health diagnosis of paranoid schizophrenia[35] and during an inpatient admission in March 2019, it was assessed that Mr E's presentation was "also suggestive of psychopathic personality disorder"[36].

2.5 Mr E's patient records indicated that he had an atypical presentation of his mental health illness, with a rapid and acute onset of psychotic symptoms. It was reported by his family that these episodes appeared generally to have occurred during the months of January to March. They also reported that there had been both historic and more recent incidents when Mr E became acutely and rapidly unwell which was usually when he was non-compliant with his prescribed antipsychotic medication, olanzapine.[37]

2.6 In March 2019 following an incident where Mr E attacked and seriously injured his grandfather, he was exhibiting symptoms of acute psychosis which led to

[32] This is a pseudonym.
[33] Section 37/45
[34] Community Mental Health Service
[35] Patient records 25 March 2020
[36] Patient records 20 March 2019 12.37pm
[37] Olanzapine is an antipsychotic medication and is often prescribed to treat the symptoms of schizophrenia Olanzapine

him being detained in hospital under Section 2 of the Mental Health Act 1983.[38]

Chronology of events

2.7 14 November 2019: Mr E was last seen at the Community Mental Health Team's (hereafter referred to as CMHT) outpatient clinic, where he reported that his mother had died. He also reported that he had stopped taking his olanzapine but agreed that he would restart this medication.

2.8 19 December 2019: Mr E cancelled his outpatient appointment with his care coordinator, citing work as the reason that he was unable to attend. It was documented Mr E 'sounded settled' and also, he was informed that his care coordinator was leaving, he was advised that a further outpatient appointment was arranged for 11 February 2020.

The following chronology has been sourced from Mr E's patient records, interviews with the involved practitioners, Mr R's family and assessments undertaken after Mr E's arrest. There was, however, some contradictory accounts and documentation related the timing of the events of 27 February 2020 that the investigation team was unable to resolve, due to the accounts being reported as hearsay and were not fully documented. Where this was the case, a comment has been added in the right-hand column of the chronology.

Date/time	Event	Comments
26/02/20	Mr R took Mr E to the GP due to concerns that his mental health was deteriorating. The GP prescribed olanzapine[39] 5mg.	
27/02/20 3am	Mr E kicked in the door of his ex-father-in-law's house. His ex-father-in-law initially hid in the back porch and then moved to the back yard.	
27/02/20 9am (approx.)	A member of the family contacted the police to report that she had viewed the CCTV footage of Mr E causing criminal damage to her father's property. She also reported that Mr R was Mr E's main carer and that she was concerned about Mr E's current mental health and non-compliance with his medication.	The police did not attend until after the attack on Mr R.

[38] Section 2 of the Mental Health Act 1983 – criteria are that a person is potentially suffering from a mental disorder of a nature/degree that warrants their detention in the interests of their safety and/or the protection of others. Compulsory admission can last up to 28 days. Section 2
[39] Olanzapine

27/02/20 9a.m. (approx.)	- The medical secretary to CMHT's psychiatrist reported that when she arrived at work, she noticed that she had multiple missed calls and a voicemail message from Mr R 9am approx. - On his arrival into the office Mr E's previous care coordinator reported to CMHT's duty team that he had received a text message from Mr E, which he reported had been sent at 8.33am on 26 February. The text stated: 'here give us a buzz matey Regards [Mr E].' - The medical secretary reported that she rang Mr R, who explained his concerns about Mr E. She gave him the direct telephone number for the CMHT's duty team. - Later in the day, Mr R again telephoned the medical secretary. She recalled that Mr R sounded genuinely concerned about Mr E. He reported that Mr E was making threats towards his ex-father-in-law and that he had caused some criminal damage to his property the previous evening. She recalled asking Mr R "if he felt safe." - The medical secretary reported that she telephoned the CMHT's manager and also the duty desk to report Mr R's concerns. - Mr R rang the CMHT duty desk and reported his concerns about Mr E and the recent events and deteriorating in his mental health. He also reported that Mr E had told him that he had stopped taking his medication 8 weeks ago and that he was becoming increasingly agitated and expressing delusional thoughts. - The CMHT on-call duty practitioner informed Mr R that the decision had been made to go and assess Mr E and that it might result in Mr E being either admitted to hospital or referred to the home-based treatment team (HBTT) and/or CMHT. It was noted that Mr R agreed	There were some differing accounts of the timing of the events. It was during this interaction that the duty team identified that Mr E did not have an allocated care coordinator.

	with this plan. The duty team emailed the CMHT's on-call doctor and consultant psychiatrist to ask for advice. The on-call doctor advised that they should encourage Mr E to be concordant with his olanzapine. - Two members of the duty team went to Mr E's house, but he was not at home. Phone contact was then made with Mr E. It was reported that Mr E answered the call and reported he was at a shopping centre. - It was explained that Mr R had contacted them to express his concerns about Mr E's mental health. Mr E agreed to a meeting with one of the duty team the following morning at his home. - It was agreed that the duty team member would assess Mr E's risks the following morning. Dependant on the risks identified he might be placed on the CMHT's Red Zone until he was stabilised on his olanzapine. - It was also documented that one of the visiting duty workers would be Mr E's allocated care coordinator. It was noted that Mr E 'sounded settled' and outpatient appointment was arranged for 28 February 2020. - A STAR v2 risk assessment was completed by one of the visiting duty workers.	It was documented that Mr E sounded calm and responded appropriately to the concerns and involvement of the CMHT.
28/02/20	- 12am: Mr E was arrested for the murder of Mr R. He was subsequently transferred to a high secure hospital.	

2.9 Mr R's family reported to the investigation team that on 27 February, Mr E attended a lunch at a local Masons group, which he had wanted to join. Post incident and during a subsequent assessment Mr E reported that he had a number of conversations with some of the attendees regarding death and suicide and that he had believed the food he had eaten at the lunch contained flesh from his dead mother.

2.10 During a post incident psychiatric assessment Mr E disclosed that leading up to the incident he had been feeling increasingly paranoid. He also recalled setting up a WhatsApp group and sending out a message with his bank account details. In addition, he reported telephoning Mr R's mother asking if her son participated in persecuting him.

3 Commissioning of the investigation

3.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents as outlined in the NHS England Serious Incident Framework (2015).[40] On 1 April 2015, NHS England introduced a revised Serious Incident Framework[41], which aims:

"To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring."[42]

3.2 The incident that resulted in the death of Mr R met the following criteria for the commissioning of an independent investigation:

"When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event."[43]

Towards the end of Sancus Solution's investigation, the decision was made that the circumstances of Mr R's death met the criteria for the commissioning of a Home Office Domestic Homicide Review[44] (hereafter referred to as DHR). A virtual meeting was attended by NHS England North West, Sancus Solutions' lead investigator, Stockport's Safeguarding Adults Partnership Business Manager and the appointed Domestic Homicide Review chair. The aim of the meeting was to discuss the respective investigations' ToR to ensure that the relevant areas of concern were being fully investigated and to minimise areas of duplication.

[40] The framework seeks to support the NHS to ensure that robust systems are in place for reporting, investigating and responding to serious incidents so that lessons are learned, and appropriate action is taken to prevent future harm. Serious Incident Framework
[41] NHS Serious Incident
[42] NHS Serious Incident p10
[43] NHS Serious Incident p47
[44] Domestic Homicide Review

3.3 It is hoped that, at least, some of Mr R's family's questions, that Sancus Solutions' investigation has not been able to address, due to them being outside the remit of their investigation, will be addressed within the DHR.

Sancus Solutions

3.4 Sancus Solutions[45] is a leading national patient safety investigation and training company that has extensive experience in undertaking mental health homicide investigations and serious incident and domestic homicide reviews, which have been commissioned by NHS England, the Home Office, NHS Trusts, and other statutory and third-sector health and social care providers.

3.5 In July 2021, NHS England commissioned Sancus Solutions to undertake this investigation. Unfortunately, due to some significant difficulties in obtaining access to Mr E's Primary Care records, the investigation did not commence until February 2022.

3.6 Details of Sancus Solution's investigation team are located in appendix C.

Terms of Reference

3.7 The Terms of Reference (hereafter referred to as ToR) for this investigation are located in Appendix A.

3.8 The focus of the investigation is to:

"Analyse the patient's records to undertake a critical review of the care, treatment and services provided by the NHS, reviewing significant events and contact with services two years prior to the time of the offence. This review is to include critical review of communication and interface with wider professionals/agencies (for example but not limited to: GP, Police, Multi Agency Risk Assessment Conference (MARAC),[46] Healthcare specialists, Probation, Children's Social Services).

Source and review relevant documents to develop a comprehensive chronology of events by which to review the investigation's findings against.

Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern."

3.9 The ToR also asked the investigation to:

[45] Sancus Solutions
[46] MARAC – Multi Agency Risk Assessment Conference MARAC

"Identify any gaps, deficiencies or omissions in the NHS care and treatment received by [Mr E] provided by Greater Manchester Mental Health Foundation Trust, other health and care services involved and wider professionals/agencies (for example but not limited to: GP, Police, MARAC, Healthcare specialists, Probation, Children's Social Care Services).

The investigation will identify areas of best practice, opportunities for learning and areas where improvement is required."[47]

3.10 It was reported to the investigation team that as a result of the Trust's Serious Incident Report's findings (hereafter referred to as SIR), a number of performance issues were identified within the CMHT. The investigation team have been assured that these issues have since been managed via the Trust's Human Resource's competency processes and therefore it was agreed that they will not form part of either this investigation or recommendations.

Report

3.11 Sancus Solutions' investigation team will submit:

- A comprehensive report that focuses on the ToR. This report will be available to all the involved agencies, Mr E and members of his and Mr R's families.

- Once accepted by NHS England North West, this report, along with any agencies' action plans, will be published on NHS England's Independent Investigation Reports web page.

Evidence, methodology and interviews

3.12 During the investigation team's analysis of information that was available to services at the time of the incident, the investigation team have aimed, as far as possible, to eliminate and/or minimise hindsight or outcome bias.[48] Where this has, however, informed either interviewees or the investigators' judgements, it has been identified within the appropriate section of this report.

3.13 To both ascertain information and inform their analysis, the investigation team have obtained information and from:

[47] ToR p1

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

- Mr E's Trust's patient records.

- Unfortunately, and despite considerable efforts on the part of both NHS England North West and the investigation team, due to the closure of Mr E's most recent primary care service, only his primary care records up to 2011 were available. Where Mr E's contact with his GP, after this date, is highlighted the information has been obtained from other sources, and therefore the investigation team cannot assure its provenance.

- Interviews with the involved practitioners, service, and clinical and operational managers.

- Where there have been changes since the incident – for example, in either service and/or operational delivery – the investigation team have discussed both the changes and their impact in their interviews with the relevant operational and senior managers and practitioners.

- The investigation team have reviewed the relevant Trust's policies and procedures that were in place at the time of the incident, as well as those that have subsequently been reviewed.

- Where relevant, the investigation team have made reference to governmental strategies and best practice and clinical guidelines.

3.14 At the investigation team's request, Greater Manchester Police and Trafford Council's Children's Social Care Services agreed to complete an Individual Management Review[49] (hereafter referred to as IMR) which documented their services' involvement with Mr E and his family. Where relevant to Mr E's mental health this information has been utilised, but Sancus Solutions was not in a position to verify the information's provenance.

3.15 The investigation team have reviewed the Trust's serious incident report (hereafter referred to as SIR) and also interviewed its author.

3.16 This report includes a qualitative review of the progress the Trust has made in implementing the action plan that was developed from the SIR's recommendations.

3.17 Alongside submitting monthly progress reports to NHS England North West, Sancus Solution's lead investigator and the Trust's Head of Patient Safety have had regular virtual meetings. At these meetings both the progress of the investigation was discussed and also where the investigation team could

[49] 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

identified/request required additional information from the Trust. Without exception all request for information was promptly responded to by the Trust.

3.18 Sancus Solutions has extensive experience of undertaking complex investigations in both the public and private sectors, they also run investigative methodology and investigative skills training programmes throughout the world. The methodologies that are utilised in the mental health homicide an example incident investigations are being continually updated to ensure that they are fully compliant and adhere to the relevant national and local regulatory and investigative frameworks and methodologies: for example in preparation for the transition to the Patient Safety Incident Response Framework (PSIRF).[50], Sancus Solutions has developed their own quality assurance framework that it is currently being utilised to both monitor and evaluate progress that has been made on implementing investigations' recommendations and action plans.

3.19 Due to the unprecedented events resulting from the COVID-19 pandemic and current guidelines, all interviews have been held virtually. The investigation team have been sensitive to the ongoing challenges of the pandemic and the extraordinary pressures on the Trust's staff, while continuing to deliver complex community mental health services. They have endeavoured to ensure that these pressures are acknowledged, and that additional support has been available to all the interviewees.

3.20 For the purposes of this report, the identities of all those who were interviewed have been anonymised and they have been identified by their professional titles.

4 Involvement of families

4.1 NHS England's Serious Incident Framework directs that:

"The needs of those affected should be the primary concern of those involved in the response to and the investigation of serious incidents. Patients and their families/carers and victims' families must be involved and supported throughout … Families should be at the centre of the process and have appropriate input into investigations."[51]

4.2 The ToR asked the investigation to:

"Ensure that affected family members are informed of the investigation, the review process and are offered the opportunity to contribute to the process including developing the terms of reference; agree how updates on progress

[50] PSIRF
[51] Serious Incident Framework

will be communicated including timescales and format. Involve affected family members as fully as is considered appropriate, in liaison with Victim Support, Police and other support or advocacy organisations.

Review and assess the Trust's compliance with local policies and national guidance including the application of the Duty of Candour principles and statutory obligations including safeguarding."[52]

4.3 Throughout the course of all Sancus Solutions' investigations, the views of the families are always sought, both in relation to their experiences and also to ascertain questions they may wish to be included within the investigation's ToR. In Sancus Solutions' experience, families can provide valuable insights into where improvements to services can be made in order to possibly prevent similar incidents from occurring.

Mr R's family

4.4 After the commissioning of the investigation Sancus Solutions'' lead investigator Grania Jenkins, emailed Mr R's wife and the family's advocate to introduce Sancus Solutions, outline the purpose of the investigation and to enquire if they had any specific questions that they wished to be addressed.

4.5 It was evident to the investigation team that one of the family's overriding concerns and questions was how such a catastrophic incident occurred despite:

- Mr R reporting his concerns.

- It being reported that Mr E's mental health could become volatile very quickly, and that in the recent past this had led to him violently attacking members of his family.

- Two of Mr E's significant triggers were when he stops taking his medication, and during particular months of the year.

4.6 Throughout the course of the investigation, there have been a number of virtual meetings with Mr R's wife and members of his family. Their advocate has also been present at some of the meetings.

4.7 During these meetings, the family have asked some very insightful and pertinent questions with regard to the care, risk assessment and treatment provided to Mr E, and the responses of practitioners to Mr R's reporting his concerns about Mr E on the day before and also on the day of the incident.

[52] ToR p2

4.8 They also provided valuable information about Mr R, specifically his role in supporting Mr E, and about the events that led up to the incident.

4.9 NHS England has also provided Mr R's family with combined bi-monthly reports which contained information from Sancus Solutions' lead investigator's monthly reports.

4.10 The families' experiences and opinions have been particularly valuable in the investigation team's consideration of the following ToR:

> "Consider and comment if safeguarding procedures were followed and communication between agencies to determine the level of risk to his partners, family and children were recognised and acted upon. Comment on any views and concerns expressed by family members and whether these were addressed. Were the family informed of any risk to them that may have supported his compliance with treatment and protected them."[53]

4.11 Prior to publication and as directed by the ToR, the investigation team will "share the findings of the report in an agreed format, with affected families … seeking their comments and ensure appropriate support is in place ahead of publication"[54]. The family will also be offered copies of the report.

Mr E and his family

4.12 At the time of the investigation, Mr E was an inpatient at a high secure hospital. The investigation team held a virtual interview with Mr E.

4.13 During the interview, Mr E was given the opportunity to reflect on his mental health and the support provided by services leading up to the incident.

4.14 Mr E's current Responsible Clinician[55] (hereafter referred to as RC) was also interviewed by the investigation team. With Mr E's permission, the RC also provided copies of forensic assessments that were completed for the court hearing.

4.15 The investigation team were also provided with a number of Care Programme Approach (CPA) reports, which have been completed since Mr E has been an inpatient in the secure unit.

[53] ToR pp1/2
[54] ToR p2
[55] A Responsible Clinician has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act. Mental Health Act 1983

4.16 Prior to publication, and in consultation with Mr E's RC, the investigation team will offer to present the findings of the report to Mr E, who will also be offered a copy of the final report.

4.17 The investigation team's family liaison officer convened telephone interviews with members of Mr E's family, who provided helpful information with regard to Mr E and the events that led up to the incident. This information was extremely helpful.

4.18 The investigation team will ensure that prior to publication Mr E's family will be invited to receive a copy of the draft report and have the opportunity to meet with the family liaison officer to discuss their report's findings.

Structure of the report

The report is divided into the following sections:

- **Section 1** – documented background information.
- **Section 2** – provides a narrative chronology of the key events and services' involvement from 2018 to 2020.
- **Section 3** – reviews the appropriateness of the treatment of Mr E in the light of his health and social care needs, identifying both areas of good practice and areas of concern.
- **Section 4**- post incident.
- **Section 5** – concluding comments.

Section 1

5 Background information

5.1 It is documented that during Mr E's childhood, he had a number of emotional and conduct disorders, such as fire-setting and cruelty to animals. During his adolescence, there was some periodic involvement from child and adolescent mental health services (CAMHS).

5.2 At the age of 19 years, Mr E was initially referred to adult mental health services with reported irritability/anger management and hyperactivity issues.

5.3 Mr E reported that from 2012, he ran his own business. There were, however, reports that, at the time of the incident, Mr E's business was experiencing increasing financial difficulties. At the age of 23 years, following what was

reported to be an impulsive overdose, Mr E was diagnosed with moderate to severe depression.

5.4 Between 2011 and 2016, Mr E had three emergency admissions to hospital for incidents of self-harm, ongoing paranoid and delusional ideations, in one incident Mr E was hospitalised due to what was reported to have been an impulsive suicidal act. In 2014 Mr E was detained in hospital under Section 2 of the Mental Health Act 1983[56] he was also diagnosed with a Delusional Disorder and was prescribed for the first time.

5.5 During this time, Mr E began to claim that he was under police surveillance and that there was a police conspiracy against him. The Trust's SIR[57] documented that on one occasion (7 April 2014) one of Mr E's friends supported this claim. It is not within the remit of this report to comment on this claim, but the investigation team concluded that these claims were not a specific factor in either the deterioration in Mr E's mental health or the incident under investigation within this report. They would also expect this issue to be addresses in the DHR investigation.

5.6 During this time, it was frequently being documented that members of Mr E's family were reporting that:

- That the period when Mr E was most at risk of a relapse in his mental health was between the months of January and March.
- In the time leading up to this period, Mr E would often be non-compliant with his medication and/or would disengage himself from mental services. There would then be a pattern of rapid-onset psychosis and an escalation of Mr E's risk of violence, often towards members of his family.
- Once Mr E's mental health was stabilised with medication and/or a hospital admission, there was a pattern when he would then quickly request that his medication be reduced and/or he would become non-compliant with his medication and/or then would eventually disengage from mental health services until he next became mentally unwell.

6 Family

6.1 At the time of the incident, Mr E had two birth children and one stepchild.

6.2 The Children Service's IMR reported that from 2002, they have had only sporadic involvement with Mr E and his family.

[56] The criteria for Section 2 of the Mental Health Act 1983 - a person is assessed to be potentially suffering from a mental disorder of a nature or degree which warrants their detention in hospital in the interests of their safety and/or the protection of others Mental Health Act 1983
[57] Trust's SIR p8

6.3 In 2017, due to concerns and reports about domestic violence a Restraining Order was put in place, which only permitted Mr E to have supervised contact with his children. Children Services again became involved.

6.4 It was reported by members of his family that despite the restrictions of the Restraining Order, Mr E continued to have contact with his children outside the supervisory arrangement.

6.5 Children's Social Care Services' last involvement was in March 2019, when a referral was received from the Sex Offender Management Unit (hereafter referred to as SOMU)[58]. The referral expressed concerns that when Mr E was registering his new address at the police station, he had stated that his two children would, in the future, be staying with him overnight. In response, Children's Social Care Services made enquiries with the children's mother, the involved schools and SOMU. It was documented that the children's mother "provided reassurances that the children will not be having any contact with [Mr E] and when she feels he is well enough to see the children, there will be a third-party present. No further role was identified for Children's Social Care."[59] Following this report, the case was closed.

6.6 As previously stated, Children's Social Care Services and GMP will be contributing to the DHR so a more in-depth chronology and analysis of their involvement will be reported and considered within that report.

7 Forensic history 2016 to 2017

7.1 10 July 2016: Mr E was arrested due to an alleged sexual assault (attempted rape). He was subsequently then arrested for breach of his bail conditions, the Restraining Order and intimidating a witness. He was then charged with perverting the course of justice after he had attempted to make his victim withdraw the charges against him.

7.2 14 August 2016: The case was discussed at a Multi-Agency Risk Assessment Conference (MARAC).[60] A referral was made to MARAT[61] – now known as the

[58] Sexual Offender Management Unit (SOMU). Its role is to manage individuals subject to Sex Offender Registration under the MAPPA framework. Its functions include assessing the level of risk of harm an individual poses to others, developing a risk management plan to manage and mitigate this risk, implementing and ensuring compliance with this plan, managing the offender's impact on the public, considering the risk of reoffending, and liaising and working with other investigators and managers to share information on offenders and support potential investigations. SOMU

[59] Children Services' IMR p5

[60] A Multi-Agency Risk Assessment Conference is a meeting where agencies discuss high-risk domestic abuse cases and develop a safety plan for the victim and his/her children. Agencies taking part can include the police, Independent Domestic Violence Advisers, and health and social care services MARAC

[61] A MARAT (Multi-Agency Risk Assessment Team) – now known as a Children's First Response Multi-Agency Safeguarding Hub (MASH) – is a single point of contact for all professionals and members of the public to report concerns, request advice and share information about a child and/or family.

Children's First Response Multi-Agency Safeguarding Hub (MASH) – in relation to Mr E's contact with his children.

7.3 At Mr E's trial:

- He entered a guilty plea to sexual assault and intimidating a witness – in both cases. He was sentenced to six months' imprisonment, suspended for six months.

- A Restraining Order was in place until 20 September 2021, which prevented him from instigating any contact with certain members of his family.

- Mr E was placed on the sex offenders register for seven years – due to end on 21 September 2023 – and was supervised by a SOMU case worker.

7.4 21 October 2016: Mr E was arrested for breaching his Restraining Order and he was remanded into custody.

7.5 28 November 2016: Mr E was sentenced to six months in prison. During Mr E's imprisonment, there was one reported episode of him experiencing symptoms of psychosis. The prison's In Reach Health Service became involved and Mr E was prescribed olanzapine 10mg.

8 2017

8.1 January 2017: Mr E was released from prison.

8.2 On his release, the National Probation Service was the lead community criminal justice agency responsible for monitoring Mr E and for sharing information with other involved agencies. Mr E was required to report weekly to his probation officer, and he also engaged with Trafford Early Intervention Team (hereafter known as EIS). There was evidence of ongoing communication between Mr E's probation officer and the EIS.

8.3 Mr E was also being monitored by SOMU's Violent and Sex Offender Register (hereafter referred to as ViSOR)[62]

8.4 During some of Mr E's EIS's meetings, it was being documented that Mr E was repeatedly reporting that a police officer had befriended him. An entry made by an EIS social worker (7 July 2017) noted that a member of the family had previously corroborated this relationship. It was, however, documented in Mr E's Care Plan (20 May 2019) that this information/disclosure was an indication that he was becoming mentally unwell and that it was part of his delusional behaviours. It was also being noted that such disclosures were an

[62] The Violent and Sex Offender Register (ViSOR) is a database of records of those required to register with the police under the Sexual Offences Act 2003.

indication that Mr E's risks of relapse and violence towards others were increasing.

8.5 During 2017, Mr E was disclosing at his CMHT appointments that he had begun a new relationship with a woman, who had a young son from a previous relationship.

8.6 September 2017: Mr E's mental health was stable, and, at his request, he was discharged from the EIS. The EIS's discharge risk assessment (1 September 2017) identified that all of Mr E's risk factors to self and others were either not evident and/or were historic. In the section 'Safeguarding children/adult issues, and sexual violence to others,' it was documented that Mr E had been found guilty of sexual assault but that he did not have contact with his victims. The assessment concluded that Mr E's risk to others was "low."

8.7 It was also noted that Mr E disclosed that his strongest motivation not to breach his conditions was that he had "no intention of going back to prison … [Mr E] has 3 months left to complete his licence."[63]

8.8 There was no documentation within the EIS assessments that Mr E was on the Sex Offender Register. During this time, there was also no evidence of any ongoing interagency communication and/or assessment of the possible ongoing risk factors and/or safeguarding concerns.

8.9 The investigation team concluded that this was a significant deficit in the management of Mr E's risks where it was known that not only was he on the Sex Offender Register but also that he had a history of significant and periodic mental health crises, during which his risks to both himself and others significantly increased, particularly members of his family.

8.10 Although these deficits are of considerable concern, as this period is not within the identified time frame for this investigation, there will not be any specific recommendations to address these deficits and improve practice.

Section 2

The ToR asks the investigation team to

"Analyse the patient's records to undertake a critical review of the care, treatment and services provided by the NHS, reviewing significant events and contact with services two years prior to the time of the offence."[64]

[63] Risk assessment 1 September 2017 p6
[64] ToR p1

The following section provides a narrative chronology of the key events and services' involvement from 2018 to 2020.

9 2018 to 2019

2018

9.1 4 January 2018: Mr E was discharged from the probation service, and SOMU[65] became the lead criminal justice agency, with responsibility for the monitoring Mr E and coordinating the information-sharing between the involved agencies. There was, however, no indication in the information available to the investigation team, of any direct contact between the agencies.

9.2 15 January 2018:

- Mr E was brought into the Accident and Emergency department (A&E) by the police after being "found behaving strangely in a neighbour's garden". The ambulance crew reported that Mr E was acting like a "wild animal."[66] It was documented that Mr E's mother reported that she "had no concerns about [Mr E] and fiercely denied that he was becoming unwell"[67].

- It was documented by the Mental Health Liaison team that they were unable to assess Mr E, as he was too physically unwell. It was noted that it was suspected that Mr E was under the influence of illegal drugs, although he denied any substance misuse and refused to have any blood tests or a urine drug screen (UDS).

- It was assessed that Mr E's immediate risk to others was "low."[68]

- Mr E was subsequently discharged to the care of his GP and a referral was made to the Trust's EIS.

9.3 GMP's IMR recorded that during 2018, the police were called to a number of incidents involving Mr E where it was suspected that there had been incidents of domestic violence:

- March 2018: A female neighbour contacted the police to report her concerns about Mr E's behaviour towards her. She asked for information about Mr E using the Domestic Violence Disclosure Scheme (DVDS).[69] A

[65] SOMU were to be the lead agency until 21 September 2023
[66] Patient records 15 January 2018 4.20pm
[67] Patient records 15 January 2018 4.20pm
[68] Letter to EIS 15 January 2018 p2
[69] The Domestic Violence Disclosure Scheme (DVDS), often referred to as 'Clare's Law,' was implemented across all police forces in England and Wales in March 2014. The public can ask the police for information on their partner's criminal history and therefore know if their partner poses a risk to them. DVDS

crime report was submitted, but it was reported that the neighbour did not want further action to be taken. The police forwarded a report about this incident to the SOMU. The investigation team have no evidence that any further action was taken.

- May 2018: A female contacted the police to report that she was a victim of domestic violence (physical aggression) from Mr E. Again, there was no indication that it was reported to any Trust services and/or any action was taken.

- 27 June 2018: GMP's IMR stated that an intelligence submission by SOMU reported that although Mr E was a registered sex offender, he would not automatically receive home visits from the service. It requested that if the police had any information that Mr E was presenting a sexual risk, they should be forwarded the information to SOMU.

- 9 August 2018: The police attended an incident where Mr E had allegedly assaulted a female. The attending police officer reported that the alleged victim refused to provide a statement to support a prosecution, so no further action was taken. It was documented that the victim had recently had a baby. A Domestic Abuse, Stalking and Honour Based Violence risk assessment (DASH)[70] was completed. The victim was assessed to be at medium risk, and it was documented in the assessment that there were no mental health factors. GMP's IMR reported that a referral was submitted "for Child Social Services and Health"[71].

- 30 August 2018: The police again attended the same victim's home. It was reported that the previous day an argument had ensued when Mr E had come to the house wanting to see the baby. There had been some physical contact and the victim reportedly had sustained a small bruise. Mr E was later arrested for common assault. again, the victim refused to assist in any prosecution. The case was submitted to the Crown Prosecution Service for a charging decision, as this was the third domestic abuse allegation.

- 17 September 2018: A referral was made to Children's Social Care Services and a joint strategy meeting was convened; it is not evident if the Trust's services were invited but the outcome of the meeting reported no on-going issues/concerns about Mr E's mental health.

[70] The Domestic Abuse, Stalking and Honour Based Violence risk assessment tool (DASH) was developed by ACPO (Association of Chief Police Officers), in conjunction with Safe Lives (formerly Coordinated Action against Domestic Abuse). It is a common assessment tool for both police and non-police agencies when identifying and assessing victims of domestic abuse, stalking, harassment and honour-based violence. DASH
[71] The investigation team noted that this was not identified within Children's Services' IMR.

- Following an assessment by the police, the locks in the victim's house were changed and a DASH risk assessment assessed the risk as medium.

- Mr E's mother disclosed to the SOMU case worker that her son was continuing to have contact with his partner and their child. In response to this information, the SOMU caseworker spoke to the victim, and it was documented that she would not agree to end contact with Mr E. Due to concerns about the wellbeing and safety of the children the SOMU caseworker forwarded a referral to Children's Social Care Services who then made a number of unannounced home visits. Mr E refused to meet the social worker but agreed to have telephone contact. As part of the assessment, it was recorded that there were no mental health factors and that no further action was to be taken.

9.4 As the involvement of the other agencies is not part of this investigation it is expected that the DHR will develop the multi-agency chronology of actions taken during 2019.

9.5 It was unclear from the available documentation if the details of these incidents and the involvement of other agencies were communicated with the CHMT.

2019

9.6 7 March to 8 March 2019:

- Mr E was admitted to A&E after he had threatened members of his family with a knife and also pushed over his grandfather who sustained a serious head injury. Mr E also damaged a door at his mother's house.

- Whilst Mr E was being assessed in A&E, he assaulted members of the hospital staff and police he was subsequently transferred to a police station under Section 136[72] of the Mental Health Act 1983.

- Mr E was assessed and held under Section 2 of the Mental Health Act 1983. He was then transferred initially to a local Psychiatric Intensive Care Unit (hereafter referred to as PICU), where he was placed in seclusion due to his level of arousal, agitation and possible elevated risk of further violence.

- As part of the Mental Health Act 1983 assessment, the social worker spoke to Mr E's mother, who reported that she did not feel threatened by her son and that the door was already broken. Later, however, she disclosed that

[72] Section 136 of the Mental Health Act 1983 gives the police emergency powers to remove a person to a place of safety in the person's best interest if the person appears to be suffering from mental disorder and to be in immediate need of care or control. Mental Health Act

Mr E had verbally threatened her and a female friend and that she was "frightened"[73] of her son. It was also reported that, prior to his admission, Mr E had a knife and was threatening "to slice people's heads off"[74].

- The police informed the social worker and ward staff that Mr E had "been convicted of sexual offences to women. … Has an extensive history of domestic violence."[75]

- Mr E's patient records documented that Mr E's grandfather had sustained a significant head injury and that the "police want to come and interview [Mr E] when he is well"[76].

- During this admission Mr E disclosed that he had stopped taking his olanzapine one or two months previously. On his admission to the inpatient unit, this medication was restarted, initially at 5mg.

- It was noted that although the family denied that Mr E was taking any illegal substances, he subsequently disclosed that he had last taken cocaine in December 2018. A subsequent urine test came back negative for any illegal substances and benzodiazepines.

9.7 9 March to 10 March 2019:

- The police informed the ward that a Restraining Order was in place to prevent Mr E having any contact with his grandparents.

- The family expressed their concerns to the ward staff that Mr E was posting inappropriate posts on social media that could affect his business and also impact on certain members of his family. Mr E refused to give his phone to the ward staff.

- Mr E's olanzapine was increased to 10mg.

9.8 13 March to 17 March 2019:

- It was documented that Mr E had expressed "remorse for the incident in which he assaulted his grandfather, he stated that he was not in his right mind, and this was due to his non-compliance with his medication"[77].

- Mr E was transferred from the PICU ward to the step downward. There were no further significant incidents. Mr E was fully compliant with the ward

[73] Patient records 7 March 2019 2.17pm
[74] Patient records Mental Health Act 1983 assessment 8 March 2019 1am
[75] Patient records 7 March 2019 2.17pm
[76] Patient records 8 March 2019 7.08pm
[77] Patient records 13 March 2019 5.36pm

routine and his medication and gradually, he was granted escorted and then unescorted leave from the ward without incident.

9.9 18 March to 19 March 2019:

- Mr E rejected the suggestion that he should have his medication via a depot injection.

- As part of the discharge plan a referral was made to the Home-Based Treatment Team[78] (hereafter referred to as HBTT) and a risk assessment was completed. In the risk summary's safeguarding section, despite the recent incident where Mr E's elderly grandfather had sustained a significant head injury, the RAG rating was green (low risk).

- A phone call was made by a member of the inpatient team to Trafford Referral and Assessment team with regard to the safety and wellbeing of Mr E's children.

- The inpatient unit also informed MARAT of Mr E's admission to hospital and outlined possible safety concerns in relation to his children.

- Contact was also made with the children's mother, who was advised that Mr E should not visit the youngest child unsupervised.

9.10 20 March 2019: A STAR v2 risk assessment was completed by the inpatient unit prior to Mr E's planned discharge.

- Risk to self, substance misuse and actual or attempted sexual violence to others – assessed as past history only.

- Risk to others, threats to harm others, impulsive risky behaviours, safeguarding children/adults, and concerns from others about risk – all assessed as current and past history. In the safeguarding section, it was assessed that there were "no known concerns about the welfare of a child"[79].

- In the safeguarding sections the risks to children were assessed as green low risk and adults – amber (medium risk).

[78] HBTT is a multidisciplinary service supporting people who are in a mental health crisis or having a relapse of their existing mental illness and require intensive support. The service provides rapid assessments and treatment for patients in their home or community venues. It is an alternative to an inpatient admission or forms part of a patient's discharge plan. HBTT
[79] STAR v2 20 March 2019 p4

- The narrative section documented the incident that led up to his recent admission – assaulting his grandfather and Mr E's reported threats that he would "slice people's heads off"[80].

- Risk to self was assessed past history no evidence apart from 'non-compliance with care/treatment,' which was assessed as current and past history.

- Risk of exploitation and vulnerability: this section documented that Mr E reported that the police were "trying to manipulate him"[81].

- There was no evidence that contact was made with the police in order to clarify details of Mr E alleged on going contact with the police.

10 Home-Based Treatment Team

10.1 20 March 2019:

- Mr E was discharged from the inpatient unit to the HBTT. His discharge medication was olanzapine 10mg. He was, at this stage, being seen by HBTT on alternative days.

- It was assessed that Mr E's mental health was stable but that he would benefit from some longer-term community mental health service support.

- It was also documented that Mr E's "risk of impulsive acts will remain high"[82] and that he had made two previous suicide attempts, both by ligation. It was also noted that he had a "past history of sexual assault."[83].

- The discharging inpatient consultant documented: "community team to consider [a] referral to forensic psychiatry due to high risk when unwell … Police and CFSS to be made aware of discharge. Family aware to inform police immediately of any aggression and alert HBTT/CMHT/GP of non-compliance."[84] This was the only time that it was suggested that a forensic assessment should be actioned.

10.2 At a HBTT multidisciplinary meeting, the following information was discussed and documented that Mr E had a "history of carrying weapons. He had been in prison for assault/rape of partner (unclear). Explosive and risky."[85]The HBTT's risk assessment concluded:

[80] STAR v2 20 March 2019 p3
[81] STAR v2 20 March 2019 p3
[82] Patient records 6 April 2019 12.37pm
[83] Referral to West Trafford CMHT 25 March 2019
[84] Patient records 20 March 2019 12.55pm
[85] Patient records 3 March 2019 2pm

"Risk to self - Low at present as [Mr E] denies experiencing any suicidal thoughts with plan and intent to end his life as he identified his family as well as his cousin who is also his carer as protective factors." This was the first documentation that Mr R, alongside Mr E's mother, was identified as being a significant part of Mr E's community support. There was, however, no indication that either Mr E's mother or Mr R were asked to either contribute to the assessments or were provided with any information about the Trust's carers support services.

Risk to others – "Low at present as [Mr E] denies experiencing any paranoid ideation and nil paranoid thoughts or delusional beliefs were expressed by him or detected by the staff through the assessment. However, there is historical evidence of risks to others such as his grandfather's physical abuse, ex-partner's sexual assault as well as historical risks such as killing animals and setting fires as a child."[86]

10.3 Due to Mr E's history of sexual and physical assault it was assessed that Mr E should be seen by two members of staff and that the venue should be the Urgent Care Centre (UCC).

10.4 It was noted that Mr E had recently moved out of his mother's house into his own property.

10.5 25 March 2019:

- A referral to be made to the CMHT.
- Telephone contact was made with MARAT, it was documented that they had reported that from their perspective they had no concerns about Mr E's contact with his children, as Mr E's partner had given them assurance that Mr E would not see them unsupervised.

10.6 25 March 2019: Mr E attended an HBTT appointment with Mr R.

10.7 27 March 2019: CMHT duty team reviewed information provided by HBTT and they noted that a "forensic referral completed by inpatient team? No evidence of this in Paris[87] - will require completing. History of significant risk to others and on-going child safeguarding needs."[88] Again no further action was taken to obtain a community forensic assessment.

[86] Patient records 7 July 2019 1.13pm
[87] Paris – electronic patient records system used by the Trust.
[88] Patient records 27 March 2019 11.18am

10.8 29 March 2019: Mr E attended a CMHT's assessment appointment with Mr R, His care coordinator and the consultant psychiatrist. Assessed Mr E as being at "low risk" [89] to himself and others.

10.9 1 April 2019: Mr E contacted the HBTT to report that he got angry "at his mums and broke a door"[90]. He also reported that the door was already broken. Mr E was seen by both a HBTT Community Psychiatric Nurse (CPN) and a Support, Time and Recovery Worker (STR). Mr R attended the appointment with Mr E. No reported concerns were documented.

10.10 3 April to 14 April 2019: Mr E attended weekly HBTT appointments. There were no current concerns documented with regard to his mental health or risk factors. It was noted that Mr E was able to reflect on the events and contributory that led up to his last hospital admission. Mr R attended some of these appointments with Mr E but again there was no indication that he was invited to contribute to the assessment etc.

10.11 18 April 2019: An HBTT six-weekly medical review was convened. It was assessed that there were no significant changes in Mr E's risk or support needs. He reported that he was being fully complaint with his medication. There was no documentation to indicate if Mr R or any other member of his family were consulted or present at this review.

10.12 20 April 2019: During an HBTT support session, Mr E reported that a friend's life support machine had been switched off that day. It was noted that Mr E's emotional responses to this distressing event were proportionate. It was also documented that Mr E was still only undertaking "light duties"[91] at work, as he was aware that "taking on too much can trigger a decline in his mental state"[92].

11 Community Mental Health Team (CMHT)

11.1 23 April 2019: Following a joint visit Mr E's care was transferred from HBTT to the CMHT service and he was allocated a care coordinator.

11.2 Mr E's care plan noted:

- Mr E would be seen every one to two weeks by his care coordinator.

[89] Patient records 23 April 2019
[90] Patient records 1 April 2019 2.30pm
[91] Patient records 20 April 2019 11am
[92] Patient records 1 April 2019 2.30pm

- In the 'I need support with addictive behaviour' section, it states: "I need to avoid illicit substances as they can impact negatively on my mental state/mood."[93]

- In the 'preventing harm to children' section, it is indicated that a "risk assessment update [is] required (due to Think Children)"[94]. This section directs the assessor as follows: "If the service user has such contact, always work with your team and with partner organisations to assess any risks to the children. Use the STARv2 assessment tool, or directorate equivalent (if appropriate) to record any assessed risk. Follow guidance on the STARv2 on when a referral must be made to children's social services."[95] It was noted that a STAR v2 had been completed with information about Mr E's children was documented, together with details of the current access arrangements.

- **Safeguarding –** adults and children: this section indicated that there were neither current risk to adults nor to children. It was concerning to the investigation team there was no details documented about either Mr E being on the Sex Offenders Register or his history of domestic violence.

11.3 Mental Health Clustering Tool: identified the following:

- "problem with relationship. Mild Problem but Def present. Again, information about Mr E's recent history of domestic violence was not highlighted.

- Safeguarding children and vulnerable dependent adults: "moderately severe problem.

- Agitated behaviour/expansive mood: "severe to very severe problem"[96].

11.4 30 April 2019: The first meeting with the CMHT allocated care coordinator did not take place due to issues with the allocation of a suitable room. Before rescheduling the appointment, the care coordinator and Mr E had a conversation during which Mr E asked for the dosage of his olanzapine to be reduced, as he was experiencing some undesirable side effect. Mr E reported that he felt that he no longer needed this medication.

11.5 1 May 2019: Mr E's request to reduce his olanzapine was discussed at a CMHT multidisciplinary team meeting. It was agreed that a further outpatient appointment was needed in order to assess Mr E.

11.6 7 May 2019: The care coordinator next met with Mr E, it was noted that Mr E was very positive about his life and recent history. No risks were identified.

[93] Care plan 22 April 2019 p10
[94] CPA review 22 March 2019
[95] CPA review 22 March 2019 p2
[96] Mental Health Clustering Tool 25 April 2019, completed by care coordinator.

Again, the reduction in his medication was discussed and it was agreed that he would wait until he next met with the CMHT psychiatrist to discuss a reduction. The next scheduled appointment was in June. Mr E also agreed that the next meeting would be at his home.

11.7 20 May and 4 June 2019: The care coordinator met Mr E at his home. No concerns were identified. It was noted that HBTT has made the decision that due to Mr E's risks and recent history there should be no lone working. It was noted that the CMHT's care coordinator was, in fact, meeting Mr E alone and there is no evidence that a lone working risk assessment had been completed.

11.8 20 June 2019: At the CPA review, and at Mr E's request, it was agreed that his antipsychotic medication olanzapine would be reduced from 10mg to 7.5mg.

11.9 10 July 2019: Mr E cancelled his next home visit by his care coordinator. It was noticeable that from this point Mr E began to miss his scheduled appointments, this was similar to previous patterns when Mr E's mental health symptoms would begin to become stable, he would stop his medication and he would then disengage from CMHT services. This would often precipitate a mental health crisis for Mr E and/or also an incident of violence, usually against a member of his family.

11.10 19 July 2019: Mr E's care coordinator cancelled his appointment; it was documented that he reported to his care coordinator that he was both physically and mentally well.

11.11 30 July 2019: Mr E was not at his home at the appointment time that had been scheduled with his care coordinator.

11.12 19 August 2019: Mr E left a voicemail message for his care coordinator, apologising for not attending their last meeting and reporting that the reason for this was that his mother was very unwell.

11.13 28 August 2019: Mr E met with his care coordinator at his home. He reported that his mother was terminally ill and in a hospice. The care coordinator noted that there were no concerns about Mr E's presentation and his reported compliance with his medication regime. Mr E did not attend his next scheduled appointment - 21 October 2019.

11.14 29 October 2019: Mr E contacted his care coordinator to apologise for not attending his last appointment, the reason being that his mother had died a number of weeks earlier. He reported that he was managing his grief and declined a home visit.

11.15 14 November 2019: Mr E attended a scheduled appointment with his care coordinator and a core trainee doctor (CT). Mr E disclosed that he had stopped taking his olanzapine three weeks earlier but when challenged about this decision he agreed to recommence this medication at a reduced dose of 5mg nocte.[97] It was assessed that Mr E's mental state was stable and that he was not exhibiting any symptoms of psychosis. There was no documented evidence that any enquiry was made at this appointment as to who was supporting Mr E since his mother had died. This was the last care coordinator's face-to-face meeting with Mr E, prior to him leaving the service. Mr R attended this appointment.

11.16 18 December 2019: The care coordinator telephoned Mr E to remind him of their scheduled appointment. Mr E reported that he was unable to attend as he was "busy with his business"[98]. The care coordinator agreed to contact Mr E the following day to rearrange the meeting, there was no evidence that this occurred. There was also no indication that the care coordinator informed Mr E that either he was leaving or who was going to assume the role of care coordinator. The care coordinator documented on 18 December 2019 that he had made an outpatient appointment for Mr E on 11 February 2020 and that an outpatient appointment letter had been sent out.

11.17 24 December 2019: The departing care coordinator completed a STAR v2. The summary of all current risks was assessed as green.

11.18 The next contact the CMHT had with Mr E was when Mr R contacted, initially, the CMHT medical secretary, to report his concerns about Mr E on 27 February 2020.

Section 3

This section addresses the following ToR:

"Analyse the patient's records to undertake a critical review of the care, treatment and services provided by the NHS, reviewing significant events and contact with services two years prior to the time of the offence.

Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern."[99]

12 Risk assessment and risk management

[97] Nocte – (at) night
[98] Patient records 18 December 2019 11.45am
[99] ToR p2

With regard to risk assessments and risk management, the ToR asks the investigation team to:

> "Consider the quality of healthcare assessments on which clinical decisions were based and actions taken, including record keeping and communication. Assess the effectiveness of care and treatment received by [Mr E] including the review of the adequacy of risk assessments, risk management (including specifically the risk posed to others), cyclical nature of relapses, care planning, including carers assessment and the effectiveness of care and treatment during transitions (both between teams and within teams) and identify any missed opportunities.

Review the approach to the risk assessment and management of any identified risks for [Mr E] and how effectively staff communicated these risks with other professionals and agencies.

Determine if the service user had any previous history of abusive threatening behaviour towards others and whether this was known to any agency.

Constructively review internal and inter-agency working and communications with other professionals/agencies (for example but not limited to: GP, Police, MARAC, Healthcare specialists, Probation, Children's Social Care Services) involved with [Mr E's] care and identify any gaps and potential opportunities for improvement and make appropriate recommendations."[100]

12.1 Given the events that lead to the death of Mr R the assessment and management of Mr E's known risks has clearly been one of the central key lines of the inquiry. Questions that the investigation team have considered have included:

- How effectively were Mr E's risks and comorbidities being identified and assessed within his risk assessments and risk management plans, particularly with regard to the known history of domestic and physical violence?

- How did the involved Trust's mental health practitioners risk assess and respond to information and concerns being reported by members of Mr E's family, Mr R and other agencies?

- What was the quality and content of interagency communication and information-sharing instigated by the involved Trust's services with regard to Mr E's known risk factors?

- Additionally – and this is the question that is perhaps of most concern to Mr R's family – were the content of the risk assessments and the risk

[100] ToR p2

management adequate or a significant contributory factor to the events that led to the tragic death of Mr R?

12.2 During this review into the care and treatment of Mr E and the events that led up to Mr R's death, the investigation team have paid particular regard to the identification, assessment and management of Mr E's known:

- complex and long-standing risk history, which included incidents of domestic violence towards members of his family and possibly substance misuse.

- history of episodic and acute deterioration in his mental health

- repeated patterns of non-compliance with his medication regime and disengagement with mental health services.

12.3 In the investigation team's review of Mr E's risk assessment and management, they have referred to both national and clinical guidelines as well as the Trust's Clinical Risk Policy, which was in place at the time of the incident.

- For example, the Department of Health's Best Practice in Managing Risk Framework (2007) suggested that:

"Risk management is a core component of mental health care and the Care Programme Approach[101]. Effective care includes an awareness of a person's overall needs as well as an awareness of the degree of risk they may present to themselves or others … Risk assessment is integral to deciding on the most appropriate level of risk management and the right kind of intervention for a service user."[102]

- The Royal College of Psychiatrists' guidance Rethinking Risk to Others[103], highlights the importance of robust and longitudinal risk assessments being undertaken for all patients, but in particular those with a known history of violence. The guidance advises that:

"past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred. On an individual level, a detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm… although all risk

[101] The Care Programme Approach (CPA) is a package of care for people with mental health problems. As part of a CPA, the patient will be allocated a CPA care coordinator (usually a nurse, social worker or occupational therapist). A care plan will be reviewed at least once a year. CPA aims to support a patient's mental health recovery by helping them to identify their strengths, goals, support needs and difficulties. All care plans should include a crisis plan. CPA
[102] Best Practice in Managing Risk p5.
[103] rethinking risk

cannot be eliminated, it can be rigorously assessed, managed and mitigated."[104]

- One of the key areas highlighted in the ongoing National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH)[105] was the significance of identifying and assessing perpetrators' complex historical and presenting comorbidities and risks prior to the homicide.

- In 2017 NCISH identified the following common presenting risk factors and comorbidities in a perpetrator prior to a mental health homicide:

  "clinical characteristics of homicide offenders were that over half had a history of violence or self-harm and co-morbidities. … it [was] unusual for mental health patients to commit homicide unless there is a co-existing problem of substance misuse. … 26% were either non-adherent or missed their final service contact and were therefore not in receipt of planned treatment just prior to the homicide … [and] 13% [of] patients were non-adherent with drug treatment in the month before the homicide."[106]

  This investigation highlighted many similarities between these profiles and Mr E's comorbidities and his known historic and more recent risk factors/history.

12.4 The Royal College of Psychiatrists' guidance goes on to advise that where there is concern or evidence of a patient's risk of harm to others, it should:

"trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate … such as an HCR-20 assessment".[107,]

12.5 The guidance, however, does also warn against overreliance on and presumed effectiveness of risk assessment tools in predicting all potential future violence. It suggests that it is important to avoid:

"the notion that one size fits all. … The risks posed by those with mental health problems are much less susceptible to prediction because of the multiplicity and complex interrelation of actors underlying a person's behaviour."[108]

12.6 As part of the review and management of Mr E's risks the investigation team have also referred to the Trust's Clinical Risk Policy that was, at the time in

[104] rethinking risk
[105] NCISH is not a risk factor study but examines in detail circumstances in which deaths occur – for example, the number of deaths in certain patient groups or settings, and how common remediable factors are. NCISH
[106] NCISH
[107] HCR-20 is a structured risk assessment tool used to assess a person's probability of violence and to determine what steps are needed to protect the public. It is primarily used in forensic inpatient and community services and requires the assessor to have undergone specific HCR-20 training HCR-20
[108] rethinking risk

place. The policy acknowledges that although there is no one assessment tool that can assess risk "with complete accuracy [,] … there is a considerable body of evidence that indicates which factors are associated with risks and how formulation and judgement about risks can be made on the basis of assessment information."[109] The policy directs the assessor to adopt the following:

"Professional judgement approach to risk management, which involves the consideration of historical information in combination with current dynamic risk factors and the:

- Use of evidence-based guidelines that promote systemisation and consistency:
- Evidence-based risk formulations and formulation-based management and treatment interventions; and
- Recognising risk assessment as a continuous process, mediated by changing conditions and sensitive to change as a result of treatment and management."[110]
- The Clinical Risk Policy also advises that:

"the level of risk can change very quickly and without warning in response to a variety of different risk factors. … risk assessments need to be an on-going part of clinical practice. Reviews may be convened at key points in care based on level of risk identified, expected changes in risk, prior to change of members of the care team, and whenever circumstances or presentation changes or planned interventions have continued for a set period. In addition, there will be specific times during the care pathway when a formal documented risk assessment and/or review will be required. ….. Where there are concerns, the appropriate people have been informed and included in the decision-making process … There is a team approach to development that is multi-disciplinary and/or multi-agency."[111]

12.7 The review of Mr E's patient records revealed that a variety of risk information and risk assessments were being documented in multiple sites, including:

- Mental Health Assessment tool
- CPA assessments and reviews section- 'My relapse and Crisis Plan'

[109] Clinical Risk Policy 26 September 2019 p11
[110] Clinical Risk Policy pp3-4
[111] Clinical Risk Policy 26 September 2019 p13

- Mental Health Clustering Tool

- Liaison team's Outcomes referral and assessment tool (completed in A&E)

- Progress notes, which provided the ongoing narrative of Mr E's contact with services, some of the entries included a list of Mr E's risks.

- Admission and discharge summaries, risk formulation information sent to Mr E's GP and were also accessible to the other involved community services, such as EIS, HBTT and CMHT.

- Standard Tool for the Assessment of Risk (hereafter referred to as STAR V2)[112]

- In various Mental Health Act 1983 assessment reports.

The Trust reported that the STAR V2 is where risk information should be assessed and documented, however the investigation team did not find that all risk information was being documented within Mr E's STAR assessment.

The investigation team would suggest that there are disadvantages of risk information being located in multiple sites: for example, risk information can get overlooked or lost, or it can be time consuming from the practitioner to access information and this can result in the focus /purpose of the risk assessments becoming less accurate.

13 STAR V2

13.1 In its adult mental health services, the Trust uses a generic risk assessment tool, the STAR V2 tool at the time of the incident. The Trust's Clinical Risk Policy states that this assessment tool not only collates risk information but also:

"aims to structure risk judgement and formulation and supports clinical decision making and management plans … [The tool] combines an understanding and consideration of both static factors, such as past history and demographic considerations with dynamic factors, such as mood, mental state and current presentation that are subject to change or fluctuation."[113]

13.2 The STAR V2 tool is used to identify, consider and document risk information in the following areas:

[112] The STAR is made up of 20 dynamic items relevant to treatment and risk management, such as substance use, mental state, social skills and coping, among others. Each item is rated as both a vulnerability and a strength. STAR
[113] Clinical Risk Policy 26 September 2019 p11

- Risks to self – exploitation, vulnerability and self-neglect.

- Risks to others in the following specific categories: safeguarding children (‘“Think Child, Think Parent, Think Family’); actual, attempted and/or threats of harm to others; use of, carrying of and/or access to firearms, knives or other lethal weapons; actual or attempted sexual violence to others.

13.3 Each section asks the assessor to identify whether a particular identified risk is:

Current, past and no evidence.
There is also a narrative section after each risk category. Entries are automatically dated, and the information appears to self-populate, onto the next revised STAR V2.

13.4 Between March 2019 and February 2020, three STAR V2 assessments were completed:

- 20 March 2019 – completed during Mr E’s inpatient admission and as part of his discharge planning and referral to the HBTT. Mr E’s current risk factors of violence and safeguarding were assessed as amber (moderate risk), and all other risks were green (low risk).

- 24 December 2019 – completed by his care coordinator prior to him leaving the CMHT. Mr E’s risks were all assessed as green (low risk).

- 26 February 2020 – completed by a member of the duty team after Mr R had alerted the CMHT secretary and duty desk to his concerns about the deterioration in Mr E’s mental health. This assessor was coincidentally the practitioner who had been allocated but had not assumed the role of Mr E’s care coordinator in December 2019. Mr E’s risk of violence was assessed as amber (moderate risk), and all other risks were green (low risk).

13.5 In the investigation team’s review of the STAR V2 assessments, they had considerable concerns about the content of the ongoing identification and assessment of Mr E’s risks, particularly with regards to his risk to others, which at its highest level was only being assessed as amber (moderate risk). The concern was that the assessments were not reflecting the severity and recentness of the incidents. For example

- March 2019 the following incidents/risks were known Mr E had made an apparent unprovoked attack on his elderly grandfather, which caused a significant head injury, which resulted in a Restraining Order and police investigation was underway.

- Mr E was on the Sex Offenders Register.

- Mr E's mother had disclosed that her son had made threats to harm her and a female friend and that he had been in possession of a knife when he made these threats.

- Mr E had attacked members of A&E staff.

13.6 The last STAR V2 was completed by one of the duty workers, who went out to visit Mr E following Mr R's disclosures about Mr E's recent history of non-compliance with his medication and that he "had gone around to his fathers-in-law house at 3 a.m. and kicked his door in … [and] made verbal threats"[114].

13.7 The investigation team concluded that the duty team response to go out to see Mr E was a proportionate response. However, they concluded that given the information provided by Mr R that day and Mr E's known risk history that further action should have been taken by the duty team that night - for example to report their concerns to the team manager and/or the police, where they also could have requested that the police undertake a welfare check on Mr E.

13.8 It was evident that the risk assessments and risk management plans that were undertaken were based mainly on Mr E's self-reporting. The Clinical Risk Policy warned assessors that although:

"self-reporting by the service user is very important, [it] should not be relied upon alone, particularly if risk to children is being considered. The accuracy of information and the amount of emphasis that should be placed on the information available will need to be considered and documented in clinical records."[115]

There was no evidence that the assessors considered the reliability of the information obtained from Mr E's self-reporting, nor did they seek to validate information from either other involved agencies or his family.

13.9 The investigation team were unable to definitively conclude why Mr E's historic and more recent risk history did not prompt a more accurate risk assessment or lead to further action being taken by the duty team that evening- such as insisting that they saw Mr E. However, alongside the specific issues in relation to Mr E, it was reported that there were a combination of significant human and resource factors that resulted in the CMHT being a service that was, and continues to be, under immense pressure: for example:

- It was reported that the CMHT is a service under acute and ever-increasing pressures, in terms of the management of their existing patients but also have

[114] STAR V2 27 March 2020 p3
[115] Clinical Risk Policy 26 September 2019 p10

to accept all patients who reach the CMHT's service threshold. Case numbers that are being managed by care coordinators are very high and the services' daily focus is mostly on crisis management. It was recognised that this can result in care coordinators not having the capacity to focus on patients, such as Mr E, who appear to be functioning well in their lives and who have family to support them. It was, however, recognised that this can lead to certain patients, such as Mr E, who have substantial risk histories being overlooked. For example, it was known that Mr E ran a business where he had unsupervised access to extremely dangerous equipment, yet the potential risks of him accessing such tools, particularly when he was unwell and his known history of risks to others, was never considered or assessed as risk, even when it is suspected that his mental health was deteriorating.

- The CMHT's practitioners, who had assessed and supported Mr E, reported that he was always eloquent, in both his appearance and presentation. He also ran what he described was a successful business and he gave the impression that he had considerable insight into his mental health. He was also able to identify what actions he needed to do to remain well, which included his ongoing compliance with his medication regime. He was, therefore, not viewed as a high-risk patient that required on going intensive monitoring or that further information/details were needed to have been obtained about his Restraining Order and Sex Offending Register.

- It was reported to the investigation team that, despite on-going intensive recruitment campaigns, the CMHT service had on going difficulty recruiting and maintaining suitably qualified and experienced care coordinators and service manager. It was reported that due to recruiting difficulties, the service has to rely on bank or agency staff. Anecdotally, it was also reported that experienced staff were leaving the service to either leave the profession entirely or take up positions in other Trust's services, which involves less crisis management. It was also reported that when CMHT posts are filled, it is often with inexperienced staff, and that it takes a considerable amount of managerial time to provide them with training to reach the requisite level of skills commensurate to their position's responsibilities. It was also reported that the use of agency staff continually remains very high, which results in significant inconsistency in the service delivery. The service often is having to be crisis managed and supervised by additional senior managers, who have limited capacity to support new and inexperienced practitioners and service managers.

- It was reported that these on-going issues probably resulted in there being no effective and responsive management systems in place at the time that would have identified that there was no care coordinator allocated to Mr E.

13.10 The investigation team were informed that it was not uncommon for CMHT team manager to be recruited without having extensive experience in managing such a complex service as the CMHT. It was reported there is now intensive senior management support, supervision, IT systems and meeting structures for the on-going monitoring patients to ensure that they receive on going care coordination, risk assessments and care plans. There is also a management Leadership Programme, which incorporates a Certificate in Leadership endorsed by the Institute of Leadership and Management, available to all service managers.

13.11 The CMHT staff, who were directly involved in this case including the managerial staff, have now left the service, so it has not been possible for the investigation team to ascertain or seek evidence of how training and the learning from this case has affected/impacted on their practice and/or improved their skill base.

14 Forensic assessment

14.1 The investigation team concluded that the lack of a forensic referral and/or assessment being sourced was a significant missed opportunity as it would have enabled a comprehensive collection and assessment of specific forensic risk information, in one rather than in disparate assessment tools.

14.2 Given Mr E's forensic history the investigation team concluded that priority should have been given to involving the Trust's community forensic services, not only to undertake a forensic assessment- HCR-20 - but also to provide the CMHT with ongoing support in their assessment, management and support of Mr E.

14.3 Although the forensic assessment and analysis would not have identified Mr R specifically as a potential victim it would have provided valuable information about the potential risks that Mr E was presenting, particularly with regard to his risks to members of his family, especially the more vulnerable members of his family who had, previously been victims to his aggression.

14.4 It would have also ensured that important and up to date information with regards to the Restraining Orders and the Sex Offenders Register, could have been obtained, risk assessed and documented and would have also informed Mr E's care plans. It would have also facilitated on going multi agency communication about Mr E and his risk monitoring. As it was there no evidence of the CMHT seeking information from other involved services or agreeing joint care plans and information sharing protocol.

15 Commentary and analysis

15.1 The investigation team concluded that there were a number of significant deficits in the identification and assessment of Mr E's risk factors. The available evidence indicated the following:

- It was human rather than a systemic error that resulted in a forensic referral not being actioned.

- It was a combination of human and systemic deficits that resulted in the failure to allocate Mr E a new care coordinator.

- Given Mr E's recent risk history, particularly the risk to members of his family when he disengaged from mental health services and ceased taking his medication, were not adequately risk assessed and/or documented.

- There was no evidence of the involved Trust's practitioners instigating multi agency communication or information sharing, with regards to Mr E's risks.

15.2 Additionally on the night of the incident given the information and concerns reported by Mr R and Mr E's known risk history the investigation team concluded that more proactive action(s) should have been taken when the duty team failed to see Mr E - for example they should have sought senior management advice and/or reported the situation and the potential risk concerns directly to the police to both share risk information and agree an immediate risks management strategy.

15.3 Despite these concerning deficits in the risk assessment and the responses to Mr R's reported concerns the investigation team are unable to definitively conclude that if they had been addressed the events that lead to the tragic death of Mr R would not have occurred.

15.4 The investigation team are not going to make any direct recommendations with regard to improving the Trust, and specifically the CMHTs' risk assessments and risk management, as they have seen evidence of several significant developments that are currently been implemented within the Trust. They are, therefore, recommending that at Sancus Solution's quality assurance visit it is expected that the Trust will be in the position to provide evidence of the implementation of the new risk assessment and management processes, specifically within the CMHT service.

Recommendation 1: At Sancus Solutions' quality assurance review, the Trust should have evidence of at least one CMHT piloted scheme of the implementation of the revised risk assessment and management processes.

15.5 This investigation has highlighted what they concluded was an important issue relating to the reporting of the medical secretary's contact with Mr R on 27 February 2020. It appears that when Mr R reportedly failed to get a response from the CMHT's duty desk, he then tried, a number of times, to make telephone contact with the CMHT's medical secretary and reportedly left her at least one voicemail message.

15.6 It was also reported that when the secretary arrived at work, she noted that there had been a number of missed calls and a voice mail message from Mr R. She reported to the investigation team that when she spoke to Mr R it was evident that he was very concerned about Mr E's mental health and his behaviour. She reported that she had asked him "if he felt safe,"[116] and due to her level of concern she made direct contact with the CMHT manager and also the CMHT's psychiatrist and service manager, reporting Mr R's concerns.

15.7 This information was anecdotally reported to the investigation team during the course of their investigation. The investigation team is not questioning the validity of this interaction with Mr R, the team manager and CHT consultant psychiatrist. The investigation team were provided with an email trail between the secretary and CMHT, but it was not recorded in Mr E's patient records.

15.8 It was reported to the investigation team that it was not an unusual occurrence for either families or patients to have telephone contact with medical secretaries, as, it was reported, they are often more accessible than CMHT's practitioners and medical team. From the information provided to the investigation team it was unclear where such contact should be documented within a patient's records and if, as in this case, the lack of documentation was an isolated or a more systemic deficit. The investigation team would suggest that this issue requires further inquiry by the Trust in order to ascertain if there is a specific learning need required to ensure that all medical secretaries are aware of where they should document any contact they may have with patient and their families.

Recommendation 2: The Trust should clarify how medical secretaries are required to record any contact they have with families and patients.

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

16 Substance misuse

[116] Interview with medical secretary

16.1 Research[117] has indicated that 30-50 per cent of people with severe mental illness also have co-existing substance misuse problems. The Department of Health states that this patient group present:

> "Significant challenges to service providers due to the complexities of their physical, social, psychological and other issues associated with this condition … [This] makes the detection, assessment, treatment and the provision of good quality care even more challenging."[118]

16.2 Based on the information available the extent of Mr E's substance misuse is unclear, there were occasions when he denied any substance misuse but at other times, he disclosed that he was aware that it was a risk to his mental health and that he needed to abstain.

16.3 It was, however, reported by members of the family, who were interviewed, that in their opinion particularly after his mother's death Mr E was often observed being under the influence of illegal substances.

16.4 There was no evidence that Mr E was ever challenged about his contradictory disclosures, this was, perhaps, another example of how compelling Mr E's presentation was. Also, that the involved practitioners' reliance solely on the assumptions that Mr E was a reliable self-historian, which with the benefit of hindsight, we now are aware was not to be the case.

16.5 Mr E's ongoing reluctance to accept that his substance misuse was, the investigation team concluded, a challenge and should have been documented and risk assessed as a significant and ongoing risk factor.

16.6 It is a possibility that during times when Mr E was non-compliant with his medication and his mental health was deteriorating, he was utilising illegal substances to manage his symptom. For example, we know that Mr E stopped his medication around the time of his mother's death, and this is when the family reported noticing his behaviour was indicating, in their opinion, substance misuse.

16.7 This investigation team noted that there was little consideration of the possibility that Mr E's substance misuse problem needed to be risk assessed in order to develop an accurate picture of how it may have been contributing to his mental health presentation and risk factors.

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[117] 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 Co-morbidity

[118] DH 2004a, Care Services Improvement Partnership (CSIP) (2008) dual diagnosis is 'everyone's business' (CSIP 2008) Everyone's Business

16.8 Dual diagnosis covers a broad spectrum of mental health and substance misuse problems that an individual might be concurrently experiencing. The nature of the relationship between these two conditions is complex – for example,

- substances can have destabilising and detrimental effects on a patient's mental health or on the medication they are being prescribed for their mental health symptoms.

- a patient may be self-medicating with substances, and therefore their underlying mental health symptoms may be obscured or exacerbated.

16.9 The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide[119] identified that one of the biggest challenges facing front-line mental health services in their assessment and support of patients such as Mr E is:

"The complexity of [formulating a] diagnosis, care and treatment with service users who are at higher risk of relapse, readmission to hospital and suicide. One of the main difficulties is that there are a number of agencies involved in a person's care – mental health services and specialist rehabilitation services, organisations in the statutory and voluntary sector."[120]

16.10 One of the difficulties in achieving a diagnosis and successful recovery and treatment plan for patients, such as Mr E who are presenting with a complex number of high-risk factors, is that secondary mental health services often lack the skills for supporting patients with a dual diagnosis and have limited knowledge and awareness of local substance misuse services. It has been acknowledged that deficits can adversely affect the treatment and recovery outcomes for patients, such as Mr E.

16.11 It is also suggested that a risk for patients with dual diagnosis is that "their co-existing problem(s) are often not detected or [are] overlooked"[121]. This can result in them being misdiagnosed and/or receive inappropriate treatment. For example, there was no consideration that Mr E's symptoms, prior to his inpatient admissions, may in fact been, in part at least, withdrawal symptoms and/or side effects from illegal substances and/or legal highs.

16.12 Research and various governmental drug guidance have highlighted that successful support and management of patients, like Mr E, who are

[119] Dual Diagnosis
[120] Dual Diagnosis
[121] Mueser, K. T., Noordsy, D. L., Drake, R. E., Fox, L. (2003) Integrated Treatment for Dual Disorders: A Guide to Effective Practice, The Guilford Press A Guide to Effective Practice

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."[122]

16.13 The investigation team would suggest that in order to improve the outcomes for patients, such as Mr E, who may have a significant and ongoing substance misuse issue that the CMHT consider undertaking a review of how the service is currently managing patients who deny they are using illegal substances, but it is suspected that it is adversely affecting their mental health and engagement with services.

Recommendation 3: The Trust should undertake a review of how the CMHT assess and support patients where substance misuse is an identified risks factor.

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

17 Psychological and pharmaceutical therapies

17.1 Aside from Mr E's mental health symptoms it was known that he had multiple and complex behavioural and antisocial issues, which included a conviction for a sexual offence and historic and more recent comorbidities. Given these complexities the investigation team had some concerns that it appears that no psychosocial assessments and/or psychological interventions - such as, behavioural analysis[123], cognitive behaviour therapy (CBT) [124] or dialectical behaviour therapy (DBT[125])- were ever considered or discussed with Mr E.

17.2 Given Mr E's degree of denial, with regard to both his current and past mental health issues and offences the investigation team would suggest that engaging him in a recovery-based and/or behavioural therapy would always have been challenging, especially when, as in Mr E's case, the person is required to comply with the requirements of their Restraining Orders and the

[122] Drug Strategy 2017
[123] Behaviour analysis utilises learning principles to bring about behaviour change. Behavioural analysis
[124] CBT Cognitive behavioural therapy (CBT) is a psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing unhelpful cognitive distortions and behaviours, improving emotional regulation, and the development of personal coping strategies that target solving current problems. It is a NICE recommended therapy to manage a range of mental health issues. NICE guidelines
[125] DBT

Sex Offending Register. It is likely that such restraints would result in the patient being cautious with regard to self-disclosure and the degree of confidentiality. Additionally in Mr E's case it was evident that he refused to accept the severity of his mental health difficulties, he appeared to lack a sense of remorse for his crimes, and he was also an unreliable self-historian so it is not likely that he would engage with any therapeutic process which required a willingness and an ability to self-reflect on one's behaviours and history.

17.3 With regard to Mr E's medication olanzapine: the investigation team were of the opinion that given his presentation, particularly, when he was acutely unwell that this was a reasonable medication to be prescribed. It meets the NICE guidelines for the criteria for both prescribing and the dosage of olanzapine.

17.4 The dispensing of this medication, via a depot injection, was discussed with Mr E prior to his discharge from the inpatient unit in 2019, but he refused to consider this option. It was, however, noted that if there were any further episodes of Mr E's non-compliance then consideration would be given to the use of a depot injection but as Mr E was not on a Community Treatment Order medication compliance could not be part of his discharge plan.

17.5 As Mr E's chronology indicates after Mr E was discharged from the inpatient unit, he quickly began requesting that the medication be reduced and/or he would stop his medication without either medical supervision or agreement as part of his care plan.

17.6 It is recognised that most medications have side effects and to encourage on going compliance it is important that a patient and their clinical team try to identify a medication that hopefully causes the minimal amount of unwanted negative side effects. It was evident that olanzapine had a significant, prompt and positive affect on Mr E's mental health symptoms, but he was repeatedly reporting that he did not like the physical side effects of this medication. For a person, such as Mr E, where physical fitness was an important part of his identity and also his working life it was, perhaps, inevitable that he was always going to stop his medication and then his engagement with services.

18 Safeguarding

The ToR ask the investigation team to:

"Consider and comment if safeguarding procedures were followed and communication between agencies to determine the level of risk to his partners, family and children were recognised and acted upon

Comment on any views and concerns expressed by family members and whether these were addressed. Were the family informed of any risk to them that may have supported his compliance with treatment and protected them[?]"[126]

18.1 At the time of Mr E's involvement, the CMHT services' safeguarding information and associated assessments were documented in a patient's CPA and STAR V2 assessment forms.

18.2 In March 2019 there was documented evidence that the AMHP, who was organising the Mental Health Act 1983, was in contact with Mr E's mother and that she provided information about the recent events that had led up to her son's recent and rapid deterioration in her son's mental health and recent assault on his elderly grandfather. During one of the telephone calls, Mr E's mother reported that her son had made direct threats towards her, that at the time, he had been in the possession of a knife and had threatened to "take everyone's heads off"[127]. She also disclosed that she was "frightened of him"[128], but later denied that this was the case.

18.3 In April 2019, following an incident when Mr E deliberately kicked and broke his mother's door, the HBTT's support worker documented that they had spoken to Mr E's mother, who reported that she did not have any "concerns, [and] she did not feel threatened"[129] by her son. It was documented that when the incident was discussed with Mr E, he focused entirely on the effect that this might have on his Restraining Order. He did not express any remorse or concern about how this might have affected his elderly mother instead it was documented that Mr E stated that he needed "to address issues with [his] anger. I don't want to be getting into any trouble."[130] Later, Mr E also disclosed that this incident had occurred in response to a "specific stressor … [and said that] the door was already damaged"[131].

18.4 Despite it being known that Mr E was:

- on the Sex Offender Register

- there had been incidents of domestic violence.

[126] ToR pp1-2
[127] Progress notes 7 March 2019 2.09pm
[128] Progress notes 7 March 2019 2.09pm
[129] Progress notes 1 April 2019 2.30pm
[130] Progress notes 1 April 2019 2.30pm
[131] Patient records 7 July 2019

- the attack on his grandfather that had caused a significant head injury.

- he had two Restraining Orders

- He had been found guilty of intimidating a witness who was also the victim of the sexual assault.

- Mr E's mother disclosed that her son was breaching the conditions of the Restraining Order.

- Mr E disclosed that it was his intention to have unsupervised access to his children when he moved house.

- The day before the incident Mr R reported that Mr E had targeted his elderly father-in law by breaking into his house at night and causing both damage and upset to him, as he was in the house at the time.

18.5 Despite all the above involved vulnerable victims there was no evidence of any practitioner or service considering/responding to possible safeguarding concerns or reporting the information via their agencies' safeguarding pathways.

18.6 The Trust's Safeguarding Adults Policy clearly outlines the safeguarding responsibilities and actions of all its staff, are required to take where there is a reported and/or suspected safeguarding concern and/or an incident. The policy states that it is designed to ensure:

"strong multiagency partnerships working together with adults to prevent abuse and neglect where possible and provides a consistent approach when responding to safeguarding concerns. This entails joint accountability for the management of risk, timely information sharing, co-operation and a collegiate approach that respects boundaries and confidentiality within legal frameworks."[132]

18.7 The policy provides very clear procedures/actions for its staff where there are known or suspected safeguarding concerns:

"Where there is immediate or continuing concern about harm to an adult with care and support needs, steps must be taken to reduce or remove that harm. Wherever possible these should be discussed with managers and be in line with local multiagency procedures. They will vary from case to case, but must be:

• Effective

[132] Safeguarding Adults Policy p6

- Timely
- Appropriate
- Necessary
- Lawful
- Consistent with the duty of care."[133]

18.8 There was no evidence that either the Trust, Local Authority's adult safeguarding teams or children's Social Care Services were contacted to provide advice and/or to raise a safeguarding alert. This, the investigation team, concluded was a significant error.

18.9 Additionally, it was noted that in Mr E's care plans that his contact with his children was identified as being his protective factor, there was no apparent inquiry, assessment or concern raised by the involved practitioners, about the recent incidents of violence against members of his family that resulted in two Restraining Orders. The investigation team would have expected that rather than Mr E's family, especially his children, be assessed as protective factors, at very least advice should have been sought by the involved practitioners as to whether any safeguarding action was required.

18.10 Based on this lack of action the investigation team were concerned by the response to potential safeguarding issues and would suggest that it has highlighted deficits in the CMHT teams with regards to their safeguarding responsibilities in this case. The investigation team is therefore recommending that as part of the ongoing learning from this case that the CMHT have specific service safeguarding training.

Recommendation 4: The CMHT's practitioners should have additional specific safeguarding training relating to the findings of Sancus Solutions and the Serious Incident Report.

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

19 Carers' involvement and support

[133] Safeguarding Adults Policy p26

19.1 Mr E's mother was documented as being Mr E's main support but by April 2019 the service's administration assistant had entered Mr R's contact details and he was referred to as Mr E's "main carer"[134].

19.2 From this point there were occasional appointments when it was documented that Mr R attended some of Mr E's HBTT and CMHT appointments.

19.3 There was no evidence that Mr E's mother or Mr R or any other members of the family were involved in any of Mr E's assessments or care/risk plans or were directed to or informed about the Trust's carers' support services, where their support needs could have been assessed and accessed the Trust or other agencies' carers' services.

19.4 The Trust recently was awarded a second gold star for its commitment to the following six key principles of the Triangle of Care[135]:

- "Carers and the essential role they play are identified at first contact or as soon as possible thereafter.
- Staff are carer aware and trained in carer engagement strategies.
- Policy and practice protocols re confidentiality and sharing information are in place.
- Defined post(s) responsible for carers are in place.
- A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway.
- A range of carer support services is available along with a self-assessment tool."[136]

It was reported that most of the Trust's wards and community services have Carer Champions, whose role is to provide information about the carer services within both the Trust and in the local area.

19.5 It has also been a key component within numerous Trust's policies and guidance - such as the Clinical Risk and Care Programme Approach Policy (2017) which directs assessors to undertake:

"a thorough assessment of health and social care needs, which will involve the service user and carer(s) as central participants in the process … Contingency/crisis plans are developed with the Service User and (if appropriate) their family/carer."[137]

19.6 The CMHT Service Operation Policy 2019 (hereafter referred to as CMHT SOP) repeatedly emphasises the importance of both "the service user and

[134] Progress notes 1 April 2019 12.01pm
[135] Triangle of Care
[136] Triangle of Care
[137] Clinical Risk Policy 2017 p12

carer as central participants"[138] to both assessment and support structures. The policy also directs that during the care planning and risk assessment processes, the assessors must "consider the views of the service user and of any carer or advocate that is involved in the service user's care"[139].

19.7 This lack of carer's support and involvement was of concern to the investigation team, as the importance of involving families and carers has, for many years, been one of the cornerstones of multiple key public health strategies. For example, the government's cross-party outcomes strategy No Health Without Mental Health (2011)[140] recognised the importance of carers and families and the significant "serious and long-lasting impact on the quality of lives of individuals, their families and carers"[141]. It also emphasises the importance of "putting families and carers, at the centre of their care … enabling them to have choice and control over their lives and the services they receive"[142].

19.8 The Trust's SIR highlighted the deficits with regard to the "complexity around [Mr E's] relationships with his [previous partner] … the risk assessment does not clearly involve the family/carers. This is a significant issue which the Trust needs to review [in terms of both] the policy training and [the] development of better risk assessment and management … Communication with carers and family was less than optimal."[143]

19.9 The SIR identified the need for significant improvement in the involvement and support of families as a specific area of learning. The following areas were identified as requiring improvement:

"Contact with relatives and carers.
Contact with relatives and carer up to date carer information, alerting safeguarding concerns especially awareness of contact with children.
Crisis contact details for patient and carer and especially at time of transition.
Early warning Care plan identifying key indicators and how to assess them.
Discuss sharing these with carers or others.
What to do with an apparently independent and well individual in terms of carer contact."[144]

19.10 In response to the ToR "Comment on any views and concerns expressed by family members and whether these were addressed. Were the family

[138] CMHT SOP p38
[139] CMHT SOP p38
[140] No Health Without Mental Health
[141] No Health Without Mental Health
[142] No Health Without Mental Health
[143] SIR pp35-36
[144] SIR p37

informed of any risk to them that may have supported his compliance with treatment and protected them[?]"[145], the investigation team concluded that:

- Apart from the Mental Health Act 1983 assessment, there was no evidence that member of the family was invited to contribute to any of Mr E's assessments and care plans.

- It was noted that Mr E's mother and one of his siblings did attend some of the ward rounds during his inpatient admission in March 2019, but it was unclear if they were invited or if it was a coincidence and they had been visiting Mr E at the time.

- There was no evidence that Mr E's family were directly informed of any specific risk factors that related to them or the extended family,

- There was also no evidence that any of Mr E's family were signposted to any carers' support services.

- The investigation team agreed with the SIR authors' conclusion that "there was not a clear understanding of the safeguarding issues in this case"[146], particularly involving vulnerable adults in Mr E's family.

19.11 The investigation team concluded that secretary and the duty desk's prompt response to Mr R's reports of the significant elevation to Mr E's risks was proportionate. However, despite Mr E's past and more recent risk history being known, the overall risk summary, completed by one of the duty team, assessed Mr E's risk to others as green (low risk), was in the investigation team's assessment incorrect and did not adequately reflect Mr E's potential risks at that time.

19.12 The investigation team also concluded that Mr E's risk history should have alerted the involved practitioners that when he became unwell, the safeguarding risks to others, particularly his family, should have been automatically assessed as being at the highest level.

19.13 The investigation team reviewed the Trust's Safeguarding Adults Policy and the safeguarding training that the CMHT's practitioners had received and were satisfied with the content. They concluded that the deficits and errors that have been highlighted with regard to safeguarding adults in this case were due to human errors/factors.

19.14 As with the deficits highlighted in relation to risk assessments, the investigation team were satisfied that the SIR's recommendation adequately seeks improvement and remedial action to improve and encourage family

[145] ToR pp1-2
[146] SIR p28

involvement. They will therefore not be making any specific recommendations but will seek to review the Trust's progress at their quality assurance review.

Recommendation 5: The Trust should be able to provide evidence of improvements within the Community mental Health Team regarding family involvement and support at Sancus Solutions' Quality Assurance Review.

20 Service and operational developments

20.1 During the course of their investigation, the investigation team identified alongside Mr E's complex co morbidities there was also a combination of systemic deficits and human errors that all contributed to the events that occurred. Based on their findings, the investigation team would have been making recommendations to improve the risk assessment, and risk proformas. However, during the course of this investigation it became apparent that in response to the findings and recommendations of the SIR, and as part of the Trust's ongoing Transformation Plan[147], there have been a number of significant developments that either have been fully implemented or are currently in the process of being implemented. The investigation team decided that rather than duplicate recommendations the following section will highlight some of the Trust, and specifically CMHT services,' developments that have occurred since this incident and also how the changes might have led to a different pathway being available to Mr E.

20.2 One of the results of the Trust's ongoing Transformation Plan[148] has been:

"The transformation of services in line with the Mental Health Improvement (MHIP) Programme/specifications, and place-based care … Provision of a seamless urgent care pathway between inpatient services and the CMHTs … to ensure a rapid effective intervention responsive to service users' needs, including the capacity for increased support … CMHTs are aligned to the neighbourhood model of the Manchester Local Care Organisation."[149]

The Transformation Plan has implemented an Enhanced Community Model, which aims to make "community services more accessible and simpler to navigate for those who use them"[150].

[147] Transformation Plan
[148] In January 2017 there was a merger of Manchester Mental Health and Social Care Trust and Greater Manchester West Mental Health NHS Foundation Trust. Since the merger, a Transformation Plan has begun to be implemented.
[149] Transformation Plan pp8-9
[150] Transformation Plan

20.3 One of the tools that has been introduced to services is a Management and Supervision Tool (hereafter referred to as MaST), which aims to "reduce mental health crisis happening … [and enable] more proactive rather than reactive crisis management, [improve] service user flow, and free up resources for other people"[151].

20.4 The investigation team were provided with a PowerPoint presentation from a training event that outlines the tool's multiple functions. MaST:

- analyses information taken from PaRIS[152] to identify the patients who are or may be at risk of crisis It was reported that it has "80 per cent accuracy"[153]
- reviews the "complexities [and] factors associated with a service user's care – e.g., where there is multiple service involvement, substance misuse etc. – and assigns a complexity rating"[154]
- informs case load management and the allocation of new service users
- shows contact information
- send alerts when a service user has not been contacted/or seen in four weeks
- highlights when there are outstanding/out-of-date risk assessments and CPA reviews
- identifies the allocation and volume of the caseloads of all practitioners, including information regarding risk levels and time management
- identifies the service users who are at lowest risk of using crisis services, and who can be reviewed for potential discharge from the service
- identifies where support from other services will be required, following a patient's discharge to support their continued recovery- and
- identifies patients who are in inpatient units, or in receipt of crisis and home treatment services and when the CMHT will be required to assume overall responsibility for their management and support.

20.5 As well as managing individual case management MaST enables a more proactive rather than reactive crisis management, improves service user flow and allows for more accurate resource/capacity management.

[151] Action plan p3
[152] Trust's patient records system
[153] PowerPoint MaST presentation
[154] PowerPoint MaST presentation

20.6 All the practitioners and managers who were interviewed as part of this investigation reported that the introduction of MaST has been very significant, as it is a multifaceted tool that has facilitated improved patient and resource management. It was also reported that it is used as a supervision tool for managers to monitor practitioners' activities and capacity and as a data source in the development of services.

20.7 The investigation team concluded that if MaST had been in place in 2019, it would have alerted the team manager to the fact that a care coordinator had not assumed responsibility for Mr E in December 2019.

21 CMHT's Service Operation Policy

21.1 The investigation team were provided with the CMHT's revised Service Operation Policy (hereafter referred to as SOP) that was introduced in March 2019.

21.2 Briefly the SOP outlines:

- the CMHT's service pathway
- function of daily multidisciplinary team (MDT) meetings
- the assessment, monitoring and escalation of concerns and risks.
- the structure for the ongoing assessments and management of patients who either need to step down or up "to a higher or lower zone and/or transfers"[155].

21.3 The SOP also outlines the processes for managing new referrals, the allocating of are coordinators and the transferring patients when their care coordinator leaves the service. The SOP states:

"when a staff member hands in their notice to leave the team, they will have a supervision session with their line manager immediately to clarify the time scales and needs of all the clients on their caseload. After this initial supervision, the line manager will meet with that staff member at least twice to review the actions of the cases agreed within supervision to ensure that paperwork has been updated and reviewed, discharges are planned or carried out or step-downs have been discussed with the clinic leads. The line manager will meet with staff the week before they leave for a final supervision to review any changes in the action plan agreed … Where cases are agreed for continued care coordination they will be handed over through a direct contact with the old and new Care Coordinator as soon as possible. … Where there may be a gap between the exit of the staff member and the

[155] MDT agenda

commencement of the new member of staff who will be assuming care coordinator the line manager will have overall responsibility and will ensure that the service users know to contact the duty worker if any needs arise and ensure that the admin staff have a copy of the list of who will be taking over the clients care if they are to contact the team. It is the Team Managers' responsibility to ensure that all the cases are covered and documented with details of onward care arrangements."[156]

21.4 As the SOP was ratified and introduced in March 2019, the investigation team would suggest that it should have been fully embedded by November/December, when it was known that Mr E's care coordinator was leaving. The investigation team were unable to ascertain any systemic issue that explains why this did not occur therefore one can only assume that it was due to a human error, which involved a number of practitioners and the team manager.

21.5 The investigation team were provided with evidence of other significant changes that have been introduced and further embedded into the CMHT service since this incident. For example:

"Zoning is a whole team approach to care enabling a targeted clinical response that can adapt quickly to changes in service users' needs and risk. It encompasses a traffic light system whereby service users are placed in different zones dependant on level of need and risk, which determines the type of interventions that are offered. … The process of zoning allows for daily reviews of care; it is inclusive of the whole staff team so enhances a targeting of resources and allows for enhanced communication of service users at risk. The approach provides structured intensive case management of identified service users, safeguarding issues and where vulnerable adults are highlighted. … Zoning meetings are convened at the start of each working day, CMHT staff are expected to attend, including the team manager and the consultant psychiatrist. The meetings are chaired by the team manager or designated senior practitioner/senior manager/clinical lead."[157]

The SOP directs that risk of disengagement "needs to be systematically incorporated into the zoning discussions to inform subsequent action plans and any decisions around escalation"[158]. The SOP provides the following definitions of the different zones:

"**Red Zone:** service users who are at elevated risk and have a high level of need and are currently in crisis, maybe likely to require admission without

[156] CMHT SOP p25
[157] SOP p8
[158] SOP p8

further support and require frequent review and intensive support and / or changes to care plans and crisis plans. For service users in the red zone, the review will include consideration of previously agreed actions and, where these are not complete, what support is appropriate to ensure the actions are completed. The SOP directs that there must be regular reviews of service users in the red zone as part of care coordinators' supervision and at the MDT zoning meetings.

Amber Zone: service users who are currently neither in crisis nor being considered for step down/discharge, including:

Those for whom the current crisis has passed but are still at risk of relapse or further mental health or social crisis.
Where there exists the identification of emerging risk, which is being managed via increased input from the multi-disciplinary team.

Green Zone: service users who are settled in their mental health and social situation. They are monitored for progress with their recovery and their appropriateness for discharge. This may also include long term, low input service users, for example those who are settled but require monitoring of Clozaril or those whose needs are being met by a longer-term funded package of care."

21.6 The investigation team were informed by the CMHT practitioners who were interviewed that the MDT zoning meetings ensures that the team are able to identify and monitor any increase in a patient's risks, vulnerabilities and support needs. They also ensure that both senior management and the clinical team maintain oversight of the patients who are of concern.

21.7 Since the incident, additional management and auditing structures have also been introduced that provide ongoing processes in order to monitor CMHT service users. These include:

- CMHT Weekly Case Management Reports, which document the status of current CMHT service users, including information about their last contact with the service and if they disengaged from the service – it was reported that these reports are utilised by the team manager in CMHT practitioners' supervision sessions.

- Weekly audits, which are completed by the Urgent Care and Community Team manager and ensure that service users are being seen and are engaging with their care plans.

Caseload management and line management supervision guidance (hereafter referred to as LMS guidance)

21.8 LMS guidance outlines the following:

- the process of caseload and capacity reviews
- the caseload monitoring tool.
- the caseload management flow chart.

21.9 The revised LMS guidance provides the structure and processes for monitoring and supporting care coordinators. These processes aim to:

- "Provide a consistent approach to the review of caseloads within the CMHT to enable comparison and understanding of the nature of individual caseloads and the team caseload as a whole.
- Identify each care coordinator's workload and capacity.
- Prevent overload of individual care co-ordinators.
- Prioritise the allocation of work in accordance with the care co-ordinator's role, experience, skills and competencies.
- Highlight any unmet need."[159]

21.10 The line managers responsible for the supervision of CMHT practitioners are team managers, senior practitioners and clinical practice leads.

21.11 The LMS guidance provides the following risk colour/numerical coding that is to be used in supervision when assessing a particular patient:

- Red (5) – where there is a high, imminent and apparent risk of a patient breakdown and presentation of danger to self and/or others or the individual is at an elevated risk of relapse. For example, a service user may have complex comorbidities, be difficult to engage or be under a CTO or Section 17 of the Mental Health Act 1983[160], or they may have been an inpatient for more than six months in the last two years. Action to be taken incudes a CPA review and/or an increase in CMHT involvement/contact.

- Amber (4) – where there are high and/or significant risks, such as complex and/or multiple comorbidities and/or a history of frequent relapses requiring inpatient admission or crisis service intervention, but the patient is currently presenting with no immediate risk to self and others. They may require more frequent/regular contact with the CMHT.

[159] Caseload Management and Line Management Supervision Guidance p1
[160] Section 17 of the Mental Health Act 1983 allows for certain patients who are detained under the Mental Health Act to be granted 'leave of absence' from the hospital in which they are detained for a specified or indefinite period subject to particular conditions. Section 17

- Amber (3) – where a patient has fewer complex risks that have been assessed as being manageable, and they require "less frequent contact 4-8 hours per month"[161].

- Green (2) – where a patient's risks and "problems have a minimal impact on [their] daily [life] … Has moderate level of support from family/carers/friends. … appointments at 2/52 or 3/52 intervals."[162]

- Green (1) – very low risk, "long periods of being well, maybe a single episode. … High level of functioning or independence AND problems do not interfere with daily activities … Has a high level of support from family/carers/friends … Requires least frequent contact or occasional monitoring … Discharge from service is indicated and should be progressed."[163]

21.12 The LMS guidance also includes the pro forma that is to be used to document supervision sessions, which contains the following sections:

- Caseload monitoring – including risks, vulnerabilities and needs.

- Cases/clinical issues – a minimum of two cases are to be discussed, including a review of progress notes, care plans, risk assessments and HoNOS cluster[164] assigned. Documentation of any safeguarding issues/concerns relating to the service user.

- Training needs – mandatory and role specific as well as the practitioner's professional development.

- New policies identified and discussed.

- Practitioner's appraisal, objectives and personal development.

- The date of the next supervision and signatures from both the supervisee and the supervisor are required.

Forensic community service

21.13 Since these incidents, the Trust has developed Specialist Community Forensic Teams (SCFTs) within the Forensic Outreach Liaison (FOL) service. Their roles include providing support/advice to services regarding their management of service users who have:

[161] Caseload Management and Line Management Supervision Guidance p4
[162] Caseload Management and Line Management Supervision Guidance p4
[163] Caseload Management and Line Management Supervision Guidance p4
[164] HoNOS (Health of the Nation Outcome Scales) is a 12-scale clinician-rated measure developed by the Royal College of Psychiatrists to guide everyday clinical practice and measure health and social care outcomes in secondary care mental health services for working-age adults (18-65 years). HoNOS

- a forensic history that includes serious violence against others
- a history of substance misuse that has a significant impact on the person's risk to others.

21.14 The service provides:

- advice
- specialist forensic assessment such as HCR20 and
- forensic risk formulation.

21.15 Clearly this service would have been extremely relevant in the assessment and ongoing management of Mr E.

Section 4 Post incident

22 Duty of Candour

The ToR asked the investigation team to:

"Review and assess the Trust's compliance with local policies and national guidance including the application of the Duty of Candour[165] principles and statutory obligations."

22.1 It was very evident to the investigation team that Mr R's family's questions and concerns were very clearly documented within the Trust's SIR.

22.2 It was also evident that throughout the SIR process the author has spent time with Mr R's family to ensure that they have been supported through what has been for them an extremely complex and unfamiliar process.

22.3 The investigation team concluded that the SIR was very comprehensive and addressed both the reported family's concerns and questions and ToR. The investigation team also concluded that the report could have benefitted from an improved layout, as, at times, it was difficult to ascertain what was evidence, the voice and/or the conclusions reached by the authors.

[165] 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

22.4 It was also reported that Mr R's family have been actively involved in some of the learning events and also participated in a video where they talked about their experiences. This video had been played at some of the learning events.

22.5 All the practitioners who attended the learning events reported that although it was difficult, it had been a very powerful and important experience. It was also apparent to the investigation team that this was a beneficial experience for members of Mr R's family.

Section 5 Concluding comments.

23 Concluding comments

23.1 This was clearly a tragic event which it was evident continues to deeply affect the lives of all those involved. The investigation team would again like to express their condolences and also, their thanks to both Mr R's family and Mr E's family who generously and graciously agreed to be part of this investigation. It is also the hope of Sancus Solutions' investigation team that the findings and recommendations within this report will provide at least some answers to their questions and concerns.

23.2 One of the main aims of these investigations that are commissioned by NHS England, is to facilitate a learning environment to improve the future delivery of services and patient safety. Although the investigation team are not suggesting that any one individual practitioner was directly responsible for this tragic event but there were clearly deficits in the on-going assessments and responses to Mr E's on-going risks factors and also in the response to Mr R's reported concerns on 27 February 2020. The investigation team, however, also concluded that the evidence indicated that the last time Mr E was seen by the CMHT team, prior to February 2020, he was not presenting with high enough risks factors, to either himself or others, to have warranted either depriving him of his liberty and/or enforcing a particular pharmaceutical therapy, via the use of the powers of the Mental Health Act 1983.

23.3 Sancus Solutions' investigation team hope that the findings and recommendations of this investigation will contribute to the learning and development of all the involved services and improve practices.

24 Recommendations

Recommendation 1: At Sancus Solutions' quality assurance review, the Trust should have evidence of at least one CMHT piloted scheme of the implementation of the revised risk assessment and management processes.

Recommendation 2: The Trust should clarify how medical secretaries are required to record any contact they have with families and patients.

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

Recommendation 3: The Trust should undertake a review of how the CMHT assess and support patients where substance misuse is an identified risks factor.

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

Recommendation 4: The CMHT's practitioners should have additional specific safeguarding training relating to the findings of Sancus Solutions and the Serious Incident Report.

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

Recommendation 5: The Trust should be able to provide evidence of improvements within the Community Mental Health Team regarding family involvement and support at Sancus Solutions' Quality Assurance Review.

Appendix A Bibliography

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Appendix B -Terms of Reference

Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan, in doing so;

- Critically analyse and assess whether the internal investigation's key lines of enquiry were appropriate, have been adequately considered and explored, highlighting any areas requiring further examination.

- Identify any gaps or omissions in [Mr E] care not adequately addressed within the investigation undertaken by the Trust.

- Assess and report on the progress made against the implementation of the recommendations from the internal investigation. - consider any partially implemented recommendations and identify possible organisational barriers to full implementation providing remedial recommendations as appropriate.

- Identify any notable areas of good practice or any new developments in services as a result of the implementation of the recommendations Care and treatment Analyse the patient's records to undertake a critical review of the care, treatment and services provided by the NHS, reviewing significant events and contact with services two years prior to the time of the offence.

- This review is to include critical review of communication and interface with wider professionals/agencies (for example but not limited to: GP, Police, MARAC, Healthcare specialists, Probation, Children's Social Services). Source and review relevant documents to develop a comprehensive chronology of events by which to review the investigations findings against.

- Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern. Risk Assessment/CPA.

- Consider the quality of healthcare assessments on which clinical decisions were based and actions taken, including record keeping and communication. Assess the effectiveness of care and treatment received by [Mr E] including the review of the adequacy of risk assessments, risk management (including specifically the risk posed to others), cyclical nature of relapses, care planning, including carers assessment and the effectiveness of care and

treatment during transitions (both between teams and within teams) and identify any missed opportunities.

- Review the approach to risk the assessment and management of any identified risks for [Mr E] and how effectively staff communicated these risks with other professionals and agencies.

- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review.

- Determine if the service user had any previous history of abusive threatening behaviour towards others and whether this was known to any agency.

- Review and assess the Trust's compliance with local policies and national guidance including the application of the Duty of Candour principles and statutory obligations including safeguarding.

- Consider and comment if safeguarding procedures were followed and communication between agencies to determine the level of risk to his partners, family and children were recognised and acted upon.

- Comment on any views and concerns expressed by family members and whether these were addressed.

- Were the family informed of any risk to them that may have supported his compliance with treatment and protected them. Constructively review internal and inter-agency working and communications with other professionals/agencies (for example but not limited to: GP, Police, MARAC, Healthcare specialists, Probation, Children's Social Services) involved with [Mr E's] care and identify any gaps and potential opportunities for improvement and make appropriate recommendations.

- Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon. Deliverables/Output Provide a final written report to NHS England and NHS Improvement (that is easy to read and meets NHS England and NHS Improvement accessible information standards) within six months of receipt of all clinical care records.

Based on investigative findings, make organisational and system specific outcome focused recommendations (local, regional or national) with a priority rating and expected timescale for completion.

Share the findings of the report in an agreed format, with affected families and the perpetrator, seek their comments and ensure appropriate support is in place ahead of publication.

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 those with a legitimate interest.

Conduct an evidence-based assurance review with key stakeholders, in conjunction with the relevant CGG, 6 – 12 months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short-written report, for NHS England and NHS Improvement that can be shared with families and stakeholders which will be made public.

Appendix C 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 mental health homicide investigations, serious incidents and combined domestic homicide and mental health homicide investigations under NHS England's Serious Incident Framework. Grania holds a police qualification for investigating complex and serious crimes (PiP 2), Root Cause Analysis Methodology, family liaison support and charring Domestic Homicide Reviews.

Nina Daniel: Nina is currently working as an advocate with Advocacy After Fatal Domestic Abuse (AAFDA), supporting the families of both victims and perpetrators where there has been a domestic homicide. Nina is also a member of the Home Office Domestic Homicide Quality Assurance Panel and has previously worked in a variety of roles with Women's Aid.

Tony Hester: Director of Sancus Solutions: Tony has over 30 year's Metropolitan Police experience in Specialist Crime investigation in addition to major crime and critical incidents as a Senior Investigating Officer (SIO). This period included the management of murder and serious crime investigations. Since 2009 Tony has coordinated and managed numerous Domestic Homicide Reviews (DHRs) for Sancus Solutions where the mental health of the perpetrator and victim has been a significant and contributory factor.

Appendix D Interviewees

- Operational Manager – Trafford Community Adult Services- acting at the time.
- Team manager - Trafford- in post at the time.
- Consultant psychiatrist - North and West CMHT.
- Community psychiatrist nurse – on the duty desk and responded to Mr R's concerns.
- Team managers- North and West CMHT- in post at the time.
- CMHT medical secretary.
- Speciality Grade Doctor CMHT.
- Director of Nursing.
- Head of Operations for Trafford, Mental Health Services.
- Approved Mental Health Practitioner.
- Deputy Medical Director for Greater Manchester Mental Health, Consultant- SIR's lead investigator.
- Head of Patient Safety.
- CMHT care coordinator – prior to December 2019.
- Responsible Clinician- high secure hospital.