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An independent investigation into the care and treatment of Mr E

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Our Final Report has been written in line with the Terms of Reference for the internal investigation into the care and treatment of Mr E. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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1 Executive summary

Incident

1.1 Mr E assaulted Mr C in January 2019. Paramedics attended but sadly Mr C later died of his injuries. Mr E was arrested and later charged with murder. He subsequently received a life sentence with a minimum of 17 years to be served. Mr E was initially remanded in custody but then transferred to a secure hospital setting.

Investigation

1.2 The independent investigation follows the NHS England *Serious Incident framework* (SIF)[1] (March 2015) and the Department of Health guidance *Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services*. The terms of reference for this investigation are given in full in Appendix A.

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

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

1.5 This report was one of two investigations that were commissioned. It was initially believed that there were correlations between the two cases. However, once the investigation had started it became apparent that this was not the case. Therefore, this report has considered only the investigation into Mr E's care and treatment.

Relevant history and summary of key events

1.6 Mr E was 38 years old at the time of the incident. He had a diagnosis of paranoid schizophrenia with multiple substance misuse. He had first shown symptoms of psychosis in 2013 and was formally diagnosed in 2014. His symptoms were typically characterised by persecutory ideas, paranoia, misidentification delusions and hallucinations. He had previously been subject to two informal inpatient admissions in 2013, and under Section 2[2] of the Mental Health Act (MHA) in 2016.

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[1] NHS England Serious Incident Framework (March 2015). https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

[2] Section 2 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/2

1.7 Mr E's lifestyle was chaotic. His relationship with his partner was troubled. He had unstable housing arrangements and was, at times, homeless. He was living in a hostel at the time of the incident. Mr E was known to frequently use illicit substances, including crack cocaine, heroin and cannabis, which tended to exacerbate his symptoms of paranoia. Mr E was unemployed.

1.8 Mr E had variable relationships with his family, largely owing to his, at times, unpredictable and paranoid behaviour. However, his family tried to support him. In particular, his mother, Ms A, regularly liaised with mental health teams about his care, treatment and wellbeing.

1.9 Historically, Mr E had received support from the Early Intervention team (EIT) provided by Mersey Care NHS Foundation Trust ('the Trust'), but from 2016 onwards he was under the care of his local Community Mental Health team (CMHT). He was supported under the Care Programme Approach (CPA)[3] and had an allocated care coordinator, Care Coordinator 1. The CMHT was responsible for ordering Mr E's medication and ensuring he received it.

1.10 Ms A raised concerns with the CMHT about Mr E's wellbeing in early 2017. She reported he was acting erratically, showed growing paranoia and had started to conceal weapons on his person. The CMHT had identified similar concerns; in January 2017 during a home visit undertaken by Care Coordinator 1 and a student nurse, it was thought Mr E might be concealing a knife. The CMHT later agreed future visits should take place in a neutral site setting.

1.11 The CMHT thought Mr E would benefit from review by the Trust forensic services and sought their advice in relation to his risk and risk management. Forensic services agreed to assess Mr E subject to him being admitted to hospital. The CMHT arranged for Mr E to be assessed under the MHA in April 2017 with a view to him being admitted. Mr E was not deemed to be detainable. A professionals meeting was held a few days later and it was agreed Mr E should be referred to multi-agency public protection arrangements (MAPPA).[4] Mr E was accepted on to the MAPPA caseload the same month.

1.12 The CMHT arranged for Mr E to be assessed under the MHA again (with the police in support) twice in June 2017. Neither assessment took place. In one instance Mr E did not attend his scheduled CPA review when the assessment was to take place. In the other, he could not be located on the day.

[3] CPA: https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[4] MAPPA: https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

1.13 A second MHA assessment took place in July 2017; Mr E was not considered to be detainable.

1.14 Mr E was discharged from MAPPA in September 2017; all agreed actions had been implemented and it was considered no further steps were warranted by the professionals involved.

1.15 Mr E was arrested for carrying a bladed article in November 2017; he was charged and released the next day, pending sentencing.

1.16 Mr E agreed to an informal admission to hospital in February 2018; however, he discharged himself against medical advice just over 10 days later. Mr E did not receive a forensic assessment whilst an inpatient. His CMHT consultant did request an assessment by forensic services shortly after he was admitted, but they were advised they would need to submit another referral given the amount of time that had passed since they had first referred Mr E. Mr E discharged himself the next day.

1.17 In June 2018 Mr E was sentenced to 10 months imprisonment, suspended for 18 months, for the offence of carrying a bladed weapon in November 2017. His sentence included a 40-day Rehabilitation Activity Requirement (RAR)[5] and a Mental Health Treatment Requirement (MHTR). [6]

1.18 Mr E was arrested in July 2018 for carrying an offensive weapon (later identified as a screwdriver). A mental state examination was attempted with Mr E when he was in custody shortly after his arrest, but he was too hostile and aggressive to engage. The Criminal Justice Mental Health Liaison and Diversion team (CJLDT) recommended that he be subject to a forensic medical examination.

1.19 A forensic medical examiner (FME)[7] saw Mr E the next day and concluded he was fit to attend court. Mr E was remanded to prison where he remained for just over a month. During this time, he was under the care of prison mental health services and subject to a forensic assessment which concluded he did not require treatment in a secure setting. Mr E was released from prison at the end of August 2018.

1.20 Mr E was arrested again in early September 2018 on suspicion of burglary. He was released the next day.

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[5] RAR: https://www.gov.uk/government/publications/the-rehabilitation-activity-requirement-in-probation/rar-guidance

[6] MHTR: https://www.criminaljusticealliance.org/wp-content/uploads/Mental-Health-Treatent-Requirement.pdf

[7] FME: a medical doctor who provides medical assessment and treatment in custody.

1.21 Mr E received a six-month conditional discharge in October 2018 (in relation to his July arrest for carrying an offensive weapon) in parallel with his existing suspended sentence.

1.22 Mr E missed his CPA appointment with the CMHT in early December but attended the rescheduled appointment on 10 December 2018. No concerns were identified by his consultant psychiatrist or care coordinator during this review. This was the last time the CMHT saw Mr E.

1.23 Mr E committed the offence in early January 2019. Mr E was under the care of the CMHT and probation service at the time of the incident.

Summary findings

Risk assessment

1.24 CMHT staff were aware of Mr E's risks, what increased these risks, and what steps should be taken to mitigate his risk. This is evidenced in clinic letters. However, these were not documented in an up-to-date risk assessment or risk management plan.

1.25 Mr E did not have a comprehensive risk assessment in place at the time of the incident in January 2019.

1.26 Mr E had a generic risk management plan that was not tailored to his individual risk or updated in response to information or events. This did not reflect the CMHT's understanding of Mr E or their engagement with him.

CPA and care planning

1.27 The CMHT appropriately arranged CPA reviews in response to changes in Mr E's behaviour and to concerns identified by the CMHT or third parties (e.g., Ms A).

1.28 Mr E had a care plan that was in date at the time of the incident, but it was not completed in line with Trust policy and lacked sufficient breadth and detail to facilitate meaningful treatment. It did not reflect the CMHT's treatment aims for Mr E.

1.29 The CMHT had limited recourse to engage Mr E in treatment. He was not subject to any formal framework beyond an MHTR to ensure he engaged with his mental health care and his participation in care and treatment was voluntary.

1.30 The CMHT considered Mr E warranted a period of assessment and treatment in hospital, likely a secure setting, followed by treatment in the community

possibly under a legal framework (e.g., a Community Treatment Order (CTO)). [8]

MHA assessments

1.31 There were occasions from March 2017 onwards when the CMHT considered Mr E should be assessed under the MHA, with a view to him receiving a period of assessment and treatment in an inpatient setting.

1.32 Mr E was subject to an MHA assessment in April 2017. He was not found to be detainable.

1.33 In June 2017 arrangements were twice made to undertake MHA assessments with Mr E, during a scheduled CPA review and at home, but he did not attend the CPA review and could not be located on the day of the second assessment.

1.34 Mr E was subject to an MHA assessment in July 2017. He was found not to be detainable.

Forensic services input

1.35 Consultant 1 requested input from forensic services in March 2017 in relation to Mr E's risk assessment and a risk management plan. Forensic services were in contact with Consultant 1 about Mr E and agreed to undertake a forensic assessment with him. However, this was subject to him being admitted to inpatient services. Trust forensic services do not undertake community-based assessments. The exception to this is a step down service offered to those who have previously been in secure services.

1.36 Mr E was informally admitted to hospital in February 2018 and Consultant 1 contacted forensic services with a view to Mr E being assessed. Consultant 1 was told their original referral had been closed given the time that had passed, and they would need to resubmit the referral. Mr E discharged himself from the ward the next day.

1.37 Mr E was subject to a forensic assessment when on remand in August 2018. The assessment concluded he did not warrant ongoing treatment in a secure mental health setting and gave recommendations for ongoing treatment in prison or the community.

Internal teams and external agency working

1.38 The CMHT was proactively in contact with other Trust services and external agencies as part of its management of Mr E. These included inpatient

[8] CTO: treatment a person must adhere to whilst living in the community
https://www.legislation.gov.uk/ukpga/1983/20/section/17A

services, the CJLDT, forensic services, the police, MAPPA, prison services, Mr E's solicitor and local charities.

1.39 In particular, the CMHT proactively sought input from forensic services, liaised with the CJLDT, and Consultant 1 submitted recommendations to the court in relation to Mr E's sentencing options in early June 2018.

1.40 When Mr E was later placed on remand in July 2018, Consultant 1 contacted prison mental health services to highlight Mr E's risks and advise that a mental health alert be activated (to inform prison professionals Mr E had a history of mental health problems). When Mr E was released from prison, prison mental health services sent the CMHT a detailed discharge summary and actions, though it was unclear what recommendations in the summary had already been actioned by prison services.

1.41 In general, whilst there were some gaps in practice, there is evidence of good internal and external working between the CMHT and other services.

1.42 The exception to this is the CMHT's engagement with the probation service which lacked consistency, despite Mr E having been subject to an MHTR for several months prior to the incident. Contact between the two agencies was intermittent and they had not agreed a strategy for communicating in relation to Mr E's adherence to the conditions of his MHTR.

Mr E's drug use

1.43 Mr E routinely used illicit substances which were known to exacerbate his symptoms of paranoia and poor mental health. The CMHT took steps to help Mr E engage with addiction services, but his engagement was voluntary and he did not attend appointments made for him.

1.44 Mr E's care plan did not reflect his drug use or detail aims/goals to address this.

1.45 Consultant 1 recommended to the court in June 2018 that a Drug Rehabilitation Requirement (DRR)[9] be part of Mr E's sentence, with a view to addressing his use of illicit substances, but this was not adopted by the court due to the nature of Mr E's offence.

1.46 The Trust does not have a dual diagnosis service and uses a separate substance misuse service. However, the Trust is taking steps to embed dual diagnosis expertise within the CMHTs and has developed a local division addictions/dual diagnosis steering group. The Trust is appointing dual diagnosis advocates to each CMHT.

[9] DRR: https://www.legislation.gov.uk/ukpga/2020/17/schedule/9/part/10/enacted

Mental Health Treatment Requirement (MHTR)

1.47 Mr E received an MHTR as part of his sentence in June 2018. The probation service was the lead agency for managing Mr E's suspended sentence, but Trust and probation services were both responsible for monitoring Mr E's adherence to the MHTR and responding to any lack of compliance.

1.48 When Mr E first received the MHTR, the probation service and the CMHT did not agree an approach to monitoring his adherence to the conditions. There is no evidence they agreed what steps the CMHT should take to escalate any concerns they had in the event of Mr E not adhering to the conditions of the MHTR.

1.49 Mr E did not adhere to the conditions of his MHTR. There is little evidence of liaison between the probation service and the CMHT in relation to managing this.

Family engagement

1.50 Mr E's mother, Ms A, was actively involved in his life and the CMHT sought to regularly engage with her in relation to his management and wellbeing. She regularly contacted the team when she was concerned about Mr E's wellbeing. However, there is no evidence that a formal approach was agreed with Ms A, in terms of liaising with the CMHT, and she was not invited to contribute to Mr E's CPA reviews. This was a missed opportunity to formally receive regular input from Ms A about Mr E's mental health and wellbeing.

1.51 Ms A met the Trust's criteria for a carer and should have been signposted by the CMHT to the local authority for a carer's assessment. There is no evidence this happened. There is no evidence the CMHT offered support to Ms A in the context of being Mr E's carer.

Trust's internal investigation and process with action plan

1.52 The Trust's internal investigation was comprehensive. It utilised root cause analysis (RCA) methodology, underpinned by Trust policy and expected practice. The findings were balanced and the associated recommendations appropriate. We identified a small number of areas in which further enquiries could have been undertaken, and whilst steps were taken to engage Ms A in the investigative process, there is no evidence she was given an opportunity to provide comments about the final draft report, within which she had identified some errors.

1.53 The Trust has made significant progress in implementing its action plan, but further evidence is required to provide assurance that the action plan has been completed.

1.54 The table below details the care delivery problems (CDPs) and service delivery problems (SDPs) we identified during the investigation.

Table 1: CDPs and SDPs

CDP	SDP
Inadequate documented risk assessment and management.	Lack of formal agreed plan between the CMHT and probation service to manage Mr E's adherence to the MHTR.
Inadequate documented care plan.	Failure to implement CMHT inpatient treatment plan in February 2018.
No forensic assessment undertaken with Mr E whilst an inpatient in February 2018.	Lack of CMHT access to forensic assessments in the community.
	Lack of formalised working arrangements between the CMHT and probation service.
	Lack of Trust dual diagnosis service.

1.55 It is our view that the CMHT, particularly Consultant 1 and Care Coordinator 1, did proactively seek to manage and support Mr E's mental health. However, the lack of legal framework around his treatment meant they were largely reliant on his engagement and compliance with treatment.

1.56 The exception to this was when Mr M was subject to a MHTR. We identified a lack of joined-up working between the two agencies and the omission of a formal management plan in relation to Mr E's lack of compliance with the conditions of his MHTR.

1.57 The CMHT had a long-term treatment plan for Mr E, the initial step for which was admission to a secure setting for assessment and treatment, followed by longer-term management in the community under a legal or formal framework and possibly depot medication.

1.58 The team was unable to implement its treatment plans for Mr E, because they required either his willing engagement, or a legal framework (or formal approach e.g., MAPPA) under which to treat him, and they had not identified an alternative approach.

Conclusions and recommendations

1.59 Mr E had a diagnosis of paranoid schizophrenia with multiple substance misuse. He had a chaotic lifestyle, characterised by extensive drug use, unstable living arrangements and, at times, threatening behaviour. Mr E's engagement with the CMHT was voluntary. With the exception of an MHTR, he was not subject to any formal frameworks and the team had no recourse to mandate his engagement in care and treatment.

1.60 It is our view that the CMHT had a comprehensive understanding of Mr E's risks and a clear long-term treatment plan, but this was reliant on Mr E being subject to an inpatient admission. The CMHT was consistently trying to engage and work with Mr E although, in agreement with the Trust's internal investigation, we identified gaps in record keeping. It is of note that neither Mr E's risk assessment or care plan reflected the team's understanding of Mr E or his proposed treatment plan.

1.61 The treatment plan for Mr E was reliant on a sustained period of assessment and treatment in an inpatient setting; something which Mr E was unwilling to consider. There were occasions in 2017 when the team considered that Mr E could be detained under the MHA, and arranged assessments, but on both occasions professionals concluded he was not detainable under the MHA.

1.62 Mr E's mother was frustrated by the lack of treatment given to him and believed staff focussed on giving Mr E his medication. She was mindful he could mask his symptoms and she felt staff failed to appreciate the significance, or act effectively, in response to this. We believe the CMHT experienced similar frustrations in relation to what care and treatment they could offer Mr E given their reliance on his willingness to engage with services. For example, they arranged MHA assessments with a view to him receiving inpatient treatment, but he was not deemed to be detainable. They also requested that forensic services review Mr E; something the service would only do if Mr E was admitted. When Mr E was admitted, a forensic assessment requested by the CMHT was not carried out before Mr E discharged himself against medical advice.

1.63 The MHTR provided the probation service and the CMHT with a legal framework in which to respond to his disengagement. It is our view that the CMHT should have been proactive at the outset in agreeing an approach with the probation service to monitor and report on Mr E's adherence to the MHTR conditions, with a view to escalating to the probation service as required. Instead, at the time of the incident, several months on from Mr E receiving the MHTR, communication between the two agencies remained inconsistent.

1.64 The CMHT was largely left to manage Mr E with limited support from other Trust services and/or external agencies.

1.65 The Trust undertook a comprehensive investigation into Mr E's care and treatment. We consider its recommendations appropriate, therefore recommendations have not been included that have already been effectively captured by the Trust's action plan (e.g., improvements in relation to risk assessment and care planning). Instead, as detailed below, we recommend the clinical commissioning group (CCG), or successor integrated care board (ICB), assure itself that the Trust has successfully implemented its action plan where we have identified similar gaps in practice. In instances where we

consider the Trust recommendations do not fully address the concerns identified, we have detailed recommendations in response to these gaps.

1.66 This independent investigation has made six recommendations to be addressed to improve learning from this event.

Recommendation 1: The Trust and the probation service should agree a protocol for the management of MHTRs. This should include an information sharing agreement, key milestones for contact/meetings and escalation pathways when concerns are identified.

Recommendation 2: The Trust should review the provision of forensic services input to community services to ensure community teams have access to forensic assessments for CMHT-based high-risk service users.

Recommendation 3: The Trust should ensure that its process for involving affected families in its internal investigation process includes providing an opportunity for families to submit feedback on the draft report.

Recommendation 4: The Trust should review its CPA policy to ensure it reflects best practice guidance in relation to the involvement of the families of service users, beyond those formally considered 'carers', in CPA and care planning.

Recommendation 5: The Trust must ensure a service user's plan of care remains continuous if admitted to an inpatient ward from the community, with appropriate liaison and engagement with the community team and other services as required.

Recommendation 6: The CCG/ICB should ensure the Trust has addressed the outstanding elements of its internal investigation action plan within six months of receipt of this report.

Good practice

1.67 The Trust's internal investigation identified the "*strong leadership and tenacious approach*" of Consultant 1. We agree with this assessment. Consultant 1 worked hard to support Mr E, undertaking regular CPA reviews with him, liaising with Trust services and other agencies in relation to his care and treatment and his broader needs. Ms A spoke highly of Consultant 1 in relation to their attempts to help Mr E.

1.68 It is our view that Care Coordinator 1 also worked hard to engage Mr E in his care and treatment, trying different approaches, offering to meet him at different locations, and regularly reminding him of upcoming appointments. Care Coordinator 1 responded to concerns raised by Ms A and other agencies, attempting to contact Mr E and/or bringing forward meetings with

Consultant 1. We note that records maintained by Care Coordinator 1 about Mr E did not wholly reflect these efforts; something also identified by the Trust's internal investigation and for which there were resultant recommendations for the CMHT, but this does not detract from the assertive approach adopted by Care Coordinator 1 to engage Mr E in his care and treatment.

2 Investigation

Incident

2.1 Mr E assaulted Mr C in January 2019. Paramedics attended but sadly Mr C died of his injuries the same day. Mr E was arrested and later charged with murder. He subsequently received a life sentence with a minimum of 17 years to be served. Mr E was initially remanded in custody but shortly after was transferred to a secure hospital setting.

Approach to the investigation

2.2 The independent investigation follows the NHS England SIF[10] (March 2015) and Department of Health guidance *Article 2 of the European Convention on Human Rights and the Investigation of Serious Incidents in Mental Health Services*. The terms of reference for this investigation are given in full in Appendix A. This report was one of two investigations that were commissioned. It was initially believed that there were correlations between the two cases. However, once the investigation had started it became apparent that this was not the case. Therefore, this report has considered only the investigation into Mr E's care and treatment.

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

2.4 The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations about organisational and system learning.

2.5 The investigation was carried out by Kathryn Hyde-Bales, Associate Director for Niche. Dr Mark Potter provided clinical oversight. The investigation team will be referred to in the first-person plural in the report.

2.6 The report was peer reviewed by Dr Carol Rooney, Associate Director for Niche.

2.7 We received Mr E's clinical notes from the Trust and his GP practice. We asked the Trust to provide all documents pertaining to Mr E covering the period 1 January 2017 until the incident in January 2019. Liverpool CCG also provided information to the investigation. Full details of the documents we received can be seen in Appendix B.

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[10] NHS England Serious Incident Framework March 2015. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

2.8 We contacted the probation service with a view to involving Mr E's probation officer in the investigation. We were advised this individual was not available but were invited to submit questions in writing to the head of the local probation delivery unit (PDU) which we did and in turn received written responses.

2.9 We undertook interviews with:

- Ms A, Mr E's mother;
- Consultant 1;
- Care Coordinator 1;
- the joint lead reviewers for the Trust's internal investigation;
- the quality assurance manager, NHS Liverpool CCG; and
- the clinical quality and safety manager, NHS Liverpool CCG.

2.10 We would like to thank the interviewees for their time and contribution to the investigation.

Contact with the victim's family

2.11 We spoke to Mr C's eldest son, Mr N, via MS Teams in November 2021. We discussed the purpose of the investigation and gave him an opportunity to review and comment on the investigation draft terms of reference. He was supported by a representative from Victim Support.[11] We received feedback from Hundred Families[12] on his behalf about the terms of reference.

2.12 We provided Mr N with monthly updates on the investigation's progress.

2.13 We shared the draft report with Mr N at the end of the investigation for his review. We received feedback on his behalf from Hundred Families. We made a small number of changes, to the report, primarily providing more detail in relation to some points, as a result.

2.14 We offer Mr C's family our sincere condolences for their loss.

Contact with Mr E's family

2.15 We spoke to Mr E's mother, Ms A, via MS Teams in November 2021. We discussed the purpose of the investigation and gave her an opportunity to comment on the terms of reference. Ms A provided background information

[11] Victim Support: https://www.victimsupport.org.uk/

[12] Hundred Families: https://www.hundredfamilies.org/

about Mr E's care and treatment. Ms A submitted feedback to us about the terms of reference and submitted three questions to be addressed by the investigation, which we relayed to NHS England and NHS Improvement in its capacity as commissioner of the independent investigation. NHS England and NHS Improvement said two of the questions were within the investigation scope and should be included in the investigation. They advised that Ms A should contact the Trust in relation to her third question. We liaised with the Trust on Ms A's behalf.

2.16 We sent monthly updates to Ms A about the investigation's progress and interviewed Ms A in February 2022.

2.17 We shared the draft report with Ms A at the end of our investigation for her review. We later spoke with her via MS Teams to receive her feedback. She told us the report did not fully reflect the extent and difficulty of the situation experienced by her and her family in trying to get help for Mr E. She told us they were constantly trying to support Mr E and get him help but they were not always listened to by services. Ms A told us that she considered it was predictable that Mr E would harm someone or come to harm himself; and that in turn this serious incident was preventable.

Contact with Mr E

2.18 We contacted Mr E through his responsible clinician, who confirmed Mr E was well enough to take part in the investigation. We shared the terms of reference with Mr E through his responsible clinician.

2.19 We met Mr E in March 2022 to discuss his care and treatment.

2.20 We shared the draft report with Mr E via his healthcare team at the end of our investigation. We were told that Mr E did not review the full report but looked at parts of the executive summary. He provided no comments about the draft report.

Structure of the report

2.21 Section 3 provides a summary chronology of Mr E's care and treatment.

2.22 Section 4 examines the issues arising from the care and treatment provided to Mr E, and includes comment and analysis related to the terms of reference.

2.23 Section 5 examines the Trust's internal investigation and its progress with its resultant action plan.

2.24 Sections 6 sets out our conclusions and recommendations.

3 Mr E's chronology of care

Background information about Mr E

3.1 Mr E was 38 years old at the time of the incident and had a diagnosis of paranoid schizophrenia. He first showed symptoms of psychosis in 2013 and was formally diagnosed in 2014. His symptoms were typically characterised by persecutory ideas, paranoia, misidentification delusions and hallucinations. He had previously been subject to inpatient admissions, informally in 2013, and under Section 2 of the Mental Health Act (MHA) in 2016.

3.2 Mr E was known to the police and had historic convictions for:

- having a knife in a public place in 2007;
- grievous bodily harm (GBH) in 2009 (custodial sentence); and
- possession of drugs and a knife in public in 2015 (custodial sentence).

3.3 Mr E started taking drugs from a young age and became a frequent user of crack cocaine and heroin as an adult. His drug use exacerbated his symptoms, particularly his paranoia.

3.4 Mr E had unstable housing arrangements and was at times homeless or stayed in hostels.

3.5 Mr E had variable relationships with his family, largely owing to his, at times, unpredictable and paranoid behaviour. His mother, Ms A, regularly liaised with mental health teams about his care and treatment. Mr E was in a relationship that was characterised by periods of instability, which professionals thought negatively impacted his mental health.

3.6 Historically, Mr E had received support from the EIT, but from 2016 onwards was under the care of his local CMHT. He was supported under the CPA and had a care coordinator, Care Coordinator 1. The CMHT was responsible for ordering Mr E's medication and ensuring he received it.

3.7 At the time of the incident, Mr E was under the care of the CMHT and the probation service, and subject to an MHTR.

3.8 We set out below a summary of key events between January 2017 and the incident in January 2019. We have not detailed every (attempted) contact the CMHT had with Mr E and/or missed appointments, but we provide more information about the CMHT's attempts to contact Mr E in 'Family questions submitted to this independent investigation' (paragraphs 4.138 to 4.147).

Mr E's care and treatment 2017 – 2018

3.9 Mr E was seen by Care Coordinator 1 and a student nurse at home on 4 January 2017. No concerns were identified at the time, but the student nurse later reported seeing Mr E handling a knife. Care Coordinator 1 discussed the incident with Consultant 1, who agreed that whilst the reason for Mr E having the knife might have been harmless, further enquiries were warranted. Care Coordinator 1 agreed to contact Mr E's mother, Ms A, to ask if she had any concerns about Mr E carrying weapons.

3.10 Care Coordinator 1 and Ms A spoke in early February; Ms A identified several concerns in relation to Mr E's behaviour. Care Coordinator 1 attempted to see Mr E at home two days later, but he was not home.

3.11 Care Coordinator 1 spoke to Ms A in early March to advise her the CMHT was experiencing difficulties contacting Mr E to arrange a home visit. She told him Mr E was staying with her and had lost his phone. They spoke on 13 March, when Ms A reported Mr E was leaving the house with a knife, and again on 15 March, when she reported he was storing weapons. She described Mr E as becoming increasingly threatening and hostile, but not physically aggressive. Ms A told Care Coordinator 1 that she wanted Mr E to move out of her house. Care Coordinator 1 said Mr E would need to present as homeless at Waves of Hope[13] for help. Care Coordinator 1 told Ms A to call the police if she felt at risk from Mr E.

3.12 Consultant 1 reviewed Mr E's notes on 16 March and noted he showed evidence of increasing risk and possible signs of relapse and self-neglect. Care Coordinator 1 was due to see Mr E the next day (Consultant 1 was unavailable); Consultant 1 advised that if Mr E's risks were considered unmanageable an MHA assessment should be requested as a priority. Consultant 1 added that consideration could be given to admitting Mr E under Section 3[14] of the MHA.

3.13 Care Coordinator 1 spoke to Ms A on 17 March in advance of the home visit. Ms A said Mr E's hostility and irritability had reduced. They discussed the CMHT's plan to assess Mr E that day; Ms A felt he could be managed at home, noting he had been more unwell in the past and had not been detained. Mr E declined to engage with Care Coordinator 1 when they visited but accepted his medication.

3.14 Consultant 1 and Care Coordinator 1 undertook a CPA review with Mr E on 20 March 2017. Care Coordinator 1 updated the police about Mr E reportedly

[13] Waves of Hope was a programme that provided support in relation to homelessness, reoffending, substance and alcohol misuse and mental health. It closed in 2019.

[14] Section 3 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/3

storing weapons and submitted a Health-Risk Assessment Management Meeting (H-RAMM) referral to the CJLDT.

3.15 Consultant 1 contacted Trust forensic services on 23 March 2017 to request a consultation to devise a risk assessment and risk management plan for Mr E.

3.16 The CJLDT did not accept the H-RAMM referral because Mr E's risks were historical, and the police were not taking current action. It was agreed by Care Coordinator 1 and a member of the CJLDT that a professionals meeting should be arranged.

3.17 Consultant 1 spoke to Specialist Trainee 1 (an ST6[15] in psychiatry) from forensic services on 5 April 2017. Specialist Trainee 1 said the team were of the opinion Mr E should be assessed under the MHA and that he likely required a psychiatric intensive care unit (PICU) admission. Specialist Trainee 1 said forensic services would assess Mr E in the PICU. Consultant 1 documented in the notes the purpose of an admission would be to treat Mr E's psychosis and assess whether secure conditions were required to facilitate this. Consultant 1 noted that in the long-term consideration of clozapine[16] and treatment under a CTO following detention might be warranted for Mr E.

3.18 The CMHT liaised with the PICU (for a bed) and professionals to undertake an MHA assessment. The PICU advised that Mr E's presentation did not warrant a PICU bed and that he could be managed on an acute ward, therefore the CMHT took steps to source an acute bed.

3.19 An MHA assessment took place with Mr E, duty Consultant 1, Approved Mental Health Practitioner (AMHP)1 and Section 12 (S12) Approved Doctor 1 on 7 April 2017. Mr E presented with pressured speech, irritability and paranoia with a lack of insight. The assessing team noted Mr E had mental health issues but not to a degree that warranted an admission. Mr E was deemed not to be detainable under the MHA. He declined an informal admission; the assessing team concluded Mr E had capacity to make this decision, although noted his lack of insight might have compromised his understanding of his need for an admission.

3.20 A professionals meeting took place on 10 April 2017. The meeting was attended by Care Coordinator 1, Consultant 1, the CMHT deputy manager and a member of the CJLDT. It was agreed that Mr E should be referred to MAPPA and that further input would be sought from Trust forensic services in relation to his risk management. The CMHT planned to request information from police liaison about Mr E's forensic history and request that a custody alert go on his record to trigger an MHA assessment should he be arrested

[15] An ST6 is a specialist trainee who is in their sixth year of specialist training (e.g., psychiatry).

[16] Clozapine: an antipsychotic https://bnf.nice.org.uk/drug/clozapine.html

and held in police custody. It was agreed future contact with Mr E should be undertaken at a neutral venue due to his risk. Consultant 1 intended to speak to Ms A to get more information about Mr E (they spoke later that day).

3.21 A MAPPA meeting took place on 26 April 2017. Consultant 1, Care Coordinator 1 and members of the CJLDT attended. Mr E's risks were noted to be psychosis, drug use, carrying weapons, delusions/paranoia and a lack of insight. It was agreed the care team would assess Mr E with a view to considering an MHA assessment. Mr E was categorised as MAPPA Level 2, Category 3:

"*Level 2: Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multi-agency public protection meetings about the offender.*

Category 3: Other dangerous offenders who have committed an offence in the past and are considered to pose a risk of serious harm to the public."[17]

3.22 Mr E required multi-agency management and was considered a high risk of harm to others.

3.23 A CPA review took place with Mr E, Consultant 1 and Care Coordinator 1 on 2 May 2017. Consultant 1 concluded Mr E was not detainable based on his presentation. Mr E missed a review with the team on 18 May 2017.

3.24 Ms A contacted the CMHT on 8 June asking to speak to Care Coordinator 1 who was initially unavailable. She said Mr E's mental health had deteriorated and he was extremely paranoid. Care Coordinator 1 called Ms A back and they discussed Mr E's presentation. Ms A said she was very worried about Mr E and asked that he be admitted – she had contacted Careline[18] the night before to request an MHA assessment for him, but Mr E had left the house when he realised. Care Coordinator 1 noted Mr E had an appointment with the CMHT that day, but they agreed it was unlikely he would attend. Care Coordinator 1 updated Consultant 1 and the team made arrangements to undertake an MHA assessment with Mr E with the police in attendance at the appointment. Mr E did not attend the appointment.

3.25 An MHA assessment was attempted by the ST4 on call, AMHP2 and a Section 12 (S12)[19] doctor with Mr E at Ms A's home on 10 June 2017. There was no answer at the address, therefore the police, executing a Section 135[20]

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[17] MAPPA categories and levels: https://mappa.justice.gov.uk/MAPPA/view?objectID=18828016

[18] Careline: the Council contact point for adult social care referrals and enquiries.

[19] Section 12 doctor: https://www.legislation.gov.uk/ukpga/1983/20/section/12

[20] Section 135 MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/135

MHA warrant, broke through the front door. They encountered Mr E's brother who said he did not know where Mr E was, but he had been behaving erratically and was unpredictable. No further action was taken.

3.26 A professionals meeting took place on 12 June 2017. Consultant 1, Specialist Trainee 1, the CMHT deputy manager and members of the CJLDT attended. It was agreed Mr E needed a period of treatment in a secure hospital environment. The meeting envisaged Mr E would be admitted to a PICU bed under Section 3 of the MHA, where he would be assessed by forensic services as to whether CMHT input was sufficient or if medium secure services were required. The police were updated, and Mr E was reported as a missing person. Attempts were made to contact the local women's centre (and a callback requested) in relation to the potential risk Mr E presented to his partner.

3.27 Care Coordinator 1 spoke to Ms A on 19 June 2017. Ms A said she had seen Mr E the previous day, driving a car without insurance. She had taken his house key and asked that he not return to the house. She said Mr E's partner had described him as "*unstable*". Care Coordinator 1 spoke to Mr E later the same day. He appeared slightly elated and agitated but denied any concerns about his mental health.

3.28 The police emailed Care Coordinator 1 on 22 June 2017 to advise Mr E had been stopped, but not arrested, at 3am that morning and was no longer considered a missing person. Care Coordinator 1 replied that Mr E had an appointment with the team the next week. Ms A called Care Coordinator 1 the same day to report concerns about Mr E's mental health.

3.29 Consultant 1 and Care Coordinator 1 saw Mr E on 26 June 2017 for a CPA review. They had not made arrangements for an MHA assessment because it was a Monday morning which meant coordinating services in advance would have been difficult. It was noted during the meeting that Mr E had been stopped three times by the police but not arrested. Consultant 1 recommended that Mr E be assessed for an admission under Section 3 MHA. Consultant 1 submitted a request to the AMHP hub after the meeting.

3.30 A MAPPA meeting took place on 27 June 2017. It was noted that it was difficult for the CMHT to monitor Mr E due to his irregular contact with them and that he could not be seen at his mother's home due to his risks. The meeting agreed with Consultant 1's view that Mr E should be subject to assessment under Section 3 MHA. Arrangements were made to facilitate an MHA assessment at his next appointment with the team on 6 July 2017, but Mr E did not attend.

3.31 Mr E was assessed under the MHA on 10 July 2017. He was noted to be settled and showed "*few/no*" signs of psychosis. Consultant 1 and the S12

doctor concluded Mr E did not meet the criteria for detention under Section 3 MHA.

3.32 Care Coordinator 1 spoke to Ms A on 4 September 2017. She reported concerns about Mr E and that he had recently attended A&E for treatment of an infected stab wound in his chest. Mr E's accommodation remained unstable. Ms A reported concerns about Mr E's vulnerability and said he had burns on his face having fallen asleep whilst smoking which she attributed to his olanzapine[21] medication.[22]

3.33 A MAPPA meeting took place on 13 September 2017. It was noted Mr E had not been detainable under the MHA on 10 July 2017, there had been no recent police incidents, and there were no immediate concerns regarding his mental health. Mr E was discharged from MAPPA. His level of risk was documented as 'high'. Care Coordinator 1 recorded in the notes on 14 September 2017 that there was no record of a police response in relation to the stab[23] wound Ms A reported to the CMHT on 4 September 2017.

3.34 Care Coordinator 1 and Ms A were in contact during September and October 2017. Care Coordinator 1 was experiencing difficulties contacting Mr E during this time and Mr E missed his CPA review on 4 October 2017. Ms A reported concerns about Mr E's drug use, mood and mental health during this time. Ms A reported on 11 October that she felt his risk of suicide and vulnerability had increased due to his aggressive presentation in the community. Care Coordinator 1 continued to experience difficulties contacting Mr E who missed two appointments rescheduled for him in October, and a CPA review in early November.

3.35 Mr E was arrested for possession of a bladed article on 7 November 2017. He was subject to two assessments by different FMEs who did not identify any concerns. He was released the next day whilst under investigation.

3.36 Consultant 1 wrote to Consultant Forensic Psychiatrist 1 on 7 November 2017 to reiterate their request for advice about Mr E's risk management.

3.37 Mr E attended court on 23 November 2017 where he was told his case would be sent to the Crown Court. He was given unconditional bail.

3.38 Consultant 1 and Specialist Trainee 1 discussed the difficulties of trying to engage Mr E on 4 December 2017. They agreed he should be subject to an

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

[22] Ms A told us as part of her feedback about the draft report that she attributed Mr E's falling asleep to his use of recreational drugs rather than his medication (as recorded in the clinical notes by Care Coordinator 1).

[23] Ms A told us as part of feedback about the draft report that Mr E had defensive injuries on his hand from grabbing a knife and she was clear he had been stabbed in the chest. She said Care Coordinator 1 should have contacted acute services to discuss/confirm Mr E's injury.

MHA assessment with the CJLDT when he attended court. Consultant 1 made arrangements with the CJLDT who indicated there would be challenges undertaking an MHA assessment within court, suggesting application of Section 136[24] MHA through the police and A&E might be more appropriate (if Mr E was unwell and required admission). However, they agreed to complete the MHA assessment with Mr E when he next attended court on 21 December 2017. Consultant 1 said they would attend court if needed.

3.39 Mr E missed his CPA review on 11 December 2017. Care Coordinator 1 contacted Ms A on 20 December 2017 to discuss the ongoing difficulties of engaging Mr E. She reported Mr E's mental health continued to be a concern and that knives were going missing from her house. Care Coordinator 1 told Ms A to call the emergency services or CMHT if she felt Mr E's risk increased.

3.40 The CJLDT assessed Mr E when he attended for court on 21 December 2017. They concluded that although he showed some signs of paranoia and hypervigilance, he did not need additional assessment under the MHA. The CJLDT deemed Mr E fit to attend court but recommended if he was found guilty that a full psychiatric report be requested (for sentencing). The CJLDT updated Consultant 1.

Mr E's care and treatment 2018 – 2019

3.41 Mr E attended a CPA review with Consultant 1 and Care Coordinator 1 on 11 January 2018. Care Coordinator 1 made a number of contacts with Mr E during January with a view to addressing his accommodation and benefit needs, but Mr E later cancelled the appointment made for him with a support charity.

3.42 Ms A contacted Care Coordinator 1 in early February to report concerns about Mr E who she described as hostile, verbally abusive and making threats to end his life. Ms A had concerns for his wellbeing and had been unable to contact him, she had therefore contacted the police who subsequently undertook a welfare check. Mr E was found safe and well; he reported no feelings of suicide or self-harm.

3.43 Ms A called Care Coordinator 1 on 13 February 2018 to report Mr E had ongoing low moods and suicidal ideation; he had indicated to her he might be willing to consider a hospital admission. Care Coordinator 1 brought forward Mr E's CPA review with Consultant 1 to take place the next day.

3.44 Mr E attended his CPA review on 14 February 2018. He appeared depressed and his psychotic symptoms were increasing, though he retained some

[24] Section 136 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/136

insight. Mr E was willing to accept an informal hospital admission. Mr E was informally admitted to an acute ward on 16 February 2018.

3.45 Care Coordinator 1 attended a ward round on 19 February 2018. It was noted Mr E was engaging well, though Care Coordinator 1 told staff he was good at masking his symptoms. Mr E was to be granted leave on the condition he did not take drugs. Mr E utilised leave that day, although ward staff noted he smelt of cannabis when he returned to the ward.

3.46 Consultant 1 emailed Consultant Forensic Psychiatrist 1 and Specialist Trainee 1 on 19 February 2018 to ask if they would consider reviewing Mr E on the ward. Consultant 1 provided details of Mr E's history and recent events.

3.47 Mr E's leave was suspended on 20 February 2018 until a full assessment could be undertaken. It was recorded in the notes that if Mr E attempted to leave the ward "*then he is detainable due to concerns from community consultant and presentation, and should be placed on Section 5(4) and/or Section 5(2)*".[25]

3.48 Consultant Forensic Psychiatrist 2 emailed Consultant 1 and Inpatient Consultant Psychiatrist 1 (Brunswick Ward) on 26 February 2018 to advise Mr E's previous referral to forensic services had been closed and would need to be reactivated. Consultant Forensic Psychiatrist 2 asked to be invited to a CPA or ward round once the referral had been resubmitted.

3.49 Mr E discharged himself from the ward, against medical advice, on 27 February 2018. The discharge summary completed by a locum CT1 (first year Core Trainee) documented that Mr E had capacity to make this decision, however, there is no evidence of a formal capacity assessment in the notes. The discharge summary and ward notes made no reference to the 20 February 2018 entry in the notes asking that Mr E be detained under the MHA should he try to leave the ward.

3.50 On 28 February 2018, Consultant 1 spoke to Ms A (who had called earlier in the day requesting contact). Ms A said she had concerns about Mr E's wellbeing. Consultant 1 said they could see Mr E the next day and asked Ms A and the CMHT duty officer to let Mr E know (Mr E had not answered Consultant 1's phone call). Ms A was told to contact the emergency services if there was imminent risk to her or Mr E.

3.51 Mr E did not see Consultant 1 the next day but attended his CPA review on 1 March 2018. No concerns were identified.

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[25] Section 5 of the MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/5

3.52 Consultant 1 contacted the CJLDT on 7 March 2018 to advise that Mr E had said he did not intend to change his plea in relation to his November arrest, therefore her recommendations remained (e.g., that he needed a full assessment under the MHA).

3.53 Ms A called Care Coordinator 1 on 8 March 2018 to voice her concerns about the decision to let Mr E discharge himself from the ward against medical advice in February. Ms A felt he should have been detained and said he could not stay with her. Care Coordinator 1 agreed to discuss accommodation and benefits with Mr E.

3.54 Mr E attended Crown court on 9 March 2018 in relation to the November 2017 offence. He was initially remanded in custody owing to confusion as to his plea but was released the same day with a view to him returning for trial in late May.

3.55 Ms A called Care Coordinator 1 on 13 March 2018 to report that over the weekend Mr E, under the influence of drugs, had threatened to stab his brother and his brother's friend. He had been restrained by his brother to prevent him grabbing a kitchen knife. Care Coordinator 1 said they would contact Mr E to arrange an appointment, and told Ms A to contact the CMHT or police if she felt his risks increased. Care Coordinator 1 spoke to Mr E the same day. Mr E said he was stable. He agreed to meet at a local homeless charity on 15 March 2018 but did not attend the appointment.

3.56 Care Coordinator 1 called Ms A on 22 March 2018 in response to a text she had sent them. Ms A said Mr E remained homeless and appeared mentally unwell, expressing paranoid and delusional thinking. Ms A was concerned about his risk to self and others. Members of the CMHT tried to contact Mr E on 31 March and 1 April 2018 but he did not answer the phone.

3.57 Ms A reported to the CMHT on 1 April 2018 that she remained very concerned about Mr E's mental state. Earlier in the day she had seen Mr E looking dishevelled and unwell.

3.58 Ms A reported similar concerns when she spoke to Care Coordinator 1 on 6 April 2018. Care Coordinator 1 saw Mr E for a planned review the same day (Consultant 1 was on leave). Mr E reported ongoing stress and issues in relation to his partner and admitted using crack cocaine. Mr E said he was taking his medication. Care Coordinator subsequently arranged for Mr E to see Consultant 1 on 1 May 2018.

3.59 Consultant 1 and Care Coordinator 1 had a CPA review with Mr E on 1 May 2018. Mr E said he was worried about receiving a custodial sentence later that month, but added he had no active plans to harm himself. Mr E held ideas that those around him were robots or clones (Consultant 1 indicated in the notes that this was not the first time Mr E had referenced this thinking). He

admitted to ongoing crack cocaine use and to hearing voices. Consultant 1 and Care Coordinator 1 agreed Mr E should have increased visits in the run up to his court appearance. Consultant 1 subsequently wrote to Mr E's solicitor about the risks that needed to be considered if Mr E received a custodial sentence. Consultant 1 advised that Mr E would benefit from a community sentence with a DRR.

3.60 Care Coordinator 1 saw Mr E at his hostel on 15 May 2018. Mr E appeared low in mood with poor eye contact. He agreed to ongoing visits.

3.61 Mr E did not attend court on 23 May 2018 for mediation.

3.62 Mr E attended court on 31 May 2018. He declined to speak to the CJLDT but agreed they could share information with his barrister. Sentencing was stood down until the next day owing to Mr E's barrister having not seen information previously sent to him by the CMHT.[26] Sentencing was later delayed until 15 June 2018 so further reports could be compiled.

3.63 Consultant 1 wrote to the court on 6 June 2018 to advise they would be Mr E's named clinician if an MHTR was imposed as part of a community/suspended sentence order. Consultant 1 detailed the treatment requirements that would be available to Mr E, which included outpatient appointments with them, regular meetings with his care coordinator, compliance with medication, engagement in therapeutic activities, and engagement with drug and alcohol services.

3.64 Mr E attended court on 26 June 2018. He received 10 months imprisonment, suspended for 18 months, a 40-day RAR and an MHTR. Consultant 1 subsequently queried with the CJLDT whether drug treatment would be covered by the RAR and the details of the MHTR; the CJLDT advised Mr E was not suitable for a DRR, due to the nature of his offence, but drug work was part of the RAR. Consultant 1 was told to contact the probation service for further detail about the MHTR.

3.65 Mr E did not attend his CPA review on 2 July 2018. He attended the rescheduled review on 16 July 2018. Mr E presented as paranoid and delusional, but no immediate risks were identified by the team.

3.66 Ms A called Care Coordinator 1 on 24 July 2018. She said Mr E had increased his drug use and was increasingly paranoid.

[26] The solicitor's office confirmed it had received Consultant 1's letter in advance of the court date, outlining their recommendations in relation to an MHTR and DRR.

3.67 Mr E was arrested for possession of an offensive weapon[27] on 25 July 2018. The CJLDT attempted an assessment, but Mr E presented as agitated, aggressive and paranoid. He was hostile and unwilling to answer questions.

3.68 On 26 July 2018, Consultant 1 and the CJLDT agreed that Mr E should be assessed by the CJLDT and FME. Consultant 1 noted Mr E could mask his symptoms, but he was becoming increasingly unwell with escalating risk in the community. Mr E was assessed by the FME who concluded Mr E showed no abnormal thought process or masking of symptoms. The FME concluded Mr E was not detainable under the MHA and was fit for court.

3.69 On this occasion Mr E was denied bail and was remanded in custody at the local prison on 27 July 2018. Consultant 1 phoned the prison Inreach (mental health) team on 30 July 2018 asking for a callback to discuss Mr E. Consultant 1 also contacted the prison Criminal Justice Mental Health (CJMH) liaison support service to advise of Mr E's risks of suicide and increased paranoia in a hospital setting. Consultant 1 asked whether Mr E's risks had been flagged to prison services and added he was a likely candidate for a hospital transfer. Consultant 1 said they were surprised he had been deemed fit for court. The CJMH service sent a mental health alert to the prison about Mr E's risk of suicide, and included information provided by Consultant 1 (e.g., additional risk factors and consideration of clozapine or depot for treatment).

3.70 Consultant 1 received a letter from Probation Officer 1 on 30 July 2018, introducing themself as Mr E's probation officer and asking to be invited to future CPA reviews (the letter is undated, but it is assumed it was sent prior to Mr E's latest arrest).

3.71 The prison Inreach team contacted the CMHT on 31 July 2018 asking for more information about Mr E. The CMHT shared his most recent CPA review.

3.72 Consultant Forensic Psychiatrist 3 assessed Mr E on 1 August 2018. Mr E presented as psychotic, lacking insight and was experiencing persecutory ideas. Consultant Forensic Psychiatrist 3 intended to arrange a meeting with Consultant 1 and Care Coordinator 1 to get more information about Mr E. Mr E was to be allocated a care coordinator in prison.

3.73 Following discussion and receipt of further information from Consultant 1, Consultant Forensic Psychiatrist 3 referred Mr E to a medium secure unit for assessment.

3.74 Mr E was assessed by Consultant Forensic Psychiatrist 2 on 17 August 2018. Consultant Forensic Psychiatrist 2 concluded Mr E did not meet the threshold

[27] Later confirmed to be a screwdriver.

for detention under Sections 48[28] and 49[29] of the MHA. The forensic service panel later discussed Mr E’s case and concluded he should not be admitted; he was described as reasonably settled in prison, causing few problems, and he was complying with his medication. Consultant Forensic Psychiatrist 2 detailed recommendations which included referring Mr E to MAPPA with a view to holding a pre-release meeting, consideration of depot medication administered to the arm,[30] and measuring his olanzapine levels (to ensure he was taking the medication).

3.75 Mr E was granted unconditional bail and released from prison on 24 August 2018 (until sentencing in October 2018). The CJLDT informed the CMHT that afternoon. Care Coordinator 1 recorded in the notes that, in the time available, they were unable to assess whether Mr E would need stepped up care over the weekend and had been unable to contact Ms A to discuss whether Mr E would be returning home.

3.76 Mr E was arrested on suspicion of burglary on 6 September 2018. He was seen by the CJLDT and noted to be stable, though a urine test indicated crack cocaine and heroin use.

3.77 Care Coordinator 1 spoke to Ms A on 7 September 2018 after Ms A sent a text raising concerns about Mr E’s mental health and increased paranoia. Ms A was unaware he had been arrested, though said she had reported the theft of jewellery from her home to the police. Mr E was released from custody with no further action on 7 September 2018.

3.78 Care Coordinator 1 attempted to see Mr E at his hostel on 10 September 2018. Mr E had not responded to attempts to make contact earlier in the month. Hostel staff reported Mr E’s partner had been seen climbing out of his bedroom window therefore he would receive a 28-day eviction notice. Care Coordinator 1 emailed the CJLDT the same day to ask whether prison services had referred Mr E to MAPPA (as recommended by the August forensic assessment). The CJLDT replied the same day that Mr E had not been referred to MAPPA.

3.79 Care Coordinator 1 undertook a joint visit with Social Worker 1 to see Mr E on 14 September 2018. Mr E appeared agitated and slightly guarded. He refused help in relation to sourcing supported accommodation but accepted help with submitting a request to the local housing scheme to increase his banding (housing need/priority).

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[28] Section 48 MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/48

[29] Section 49 MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/49

[30] The notes indicate that Mr E had previously been reluctant to receive depot medication because it was typically administered to the buttock.

3.80 The CMHT sent Probation Officer 1 an invitation on 19 September 2018 to Mr E's next CPA (scheduled for 15 October 2018 – Probation Officer 1 was unable to attend due to annual leave). Care Coordinator 1 visited Mr E at his hostel on 21 September 2018, but the meeting could not proceed because Mr E reported he was "*stoned*".

3.81 Care Coordinator 1 spoke to Hostel Key Worker 1 on 27 September 2018. They reported there had been incidents at the hostel involving Mr E, including him threatening to "*slash*" other residents and using another resident's Personal Independence Payment (PIP).[31] They described Mr E's actions as "*bullying*".

3.82 Mr E attended court on 12 October 2018 for sentencing (the notes do not provide further detail). He declined CJLDT support. Mr E was given a six-month conditional discharge in parallel with his ongoing suspended sentence and MHTR.

3.83 A CPA review took place with Mr E on 15 October 2018. He reported no concerns and said he intended to engage with his key worker and CMHT social worker. He agreed to twice weekly visits. Care Coordinator 1 submitted a MAPPA referral to the CJLDT after the meeting. They replied on 18 October 2018, asking Care Coordinator 1 to submit the referral to "*Mrs MAPPA*".

3.84 Care Coordinator 1 visited the hostel on 31 October 2018, but Mr E was out. They visited again on 2 November and met Mr E who engaged on a minimal basis. Care Coordinator 1 told Mr E they intended to discuss Mr E's accommodation options with Social Worker 1.

3.85 Care Coordinator 1 delivered Mr E's medication on 9 November 2018. Hostel staff reported Mr E had been verbally aggressive towards other residents.

3.86 Care Coordinator 1 and Social Worker 1 attended the hostel on 15 November 2018 to discuss Mr E's accommodation needs with him. He engaged briefly before abruptly ending the meeting.

3.87 Mr E did not attend his CPA review on 3 December 2018.

3.88 Care Coordinator 1 spoke to Probation Officer 1 on 4 December 2018. Probation Officer 1 confirmed Mr E was under an MHTR and a suspended sentence – they said if Mr E continued to disengage with services, he could be in breach of the MHTR. Probation Officer 1 was due to meet Mr E on 6 December 2018 when they intended to remind him of the importance of adhering to the conditions of his MHTR. They said Mr E had engaged minimally to date and had missed several planned appointments. When he

[31] PIP: additional funds for those with an illness, mental health illness or disability https://www.gov.uk/pip

did attend, he presented as abrupt, frustrated and aggressive, often with a taxi waiting outside.

3.89 Consultant 1 and Care Coordinator 1 saw Mr E for a CPA review on 10 December 2018. Mr E reported no concerns, and his next CPA was scheduled to take place three months later. This was the last time CMHT staff saw Mr E before the incident in January 2019. Consultant 1 sent an abridged clinic letter to Probation Officer 1 detailing the CPA review but advising that Mr E had not given consent for the full review to be shared. Consultant 1 confirmed Mr E's mental state was stable and his compliance with medication was "*fairly good*". They noted they were awaiting the outcome of the MAPPA referral.

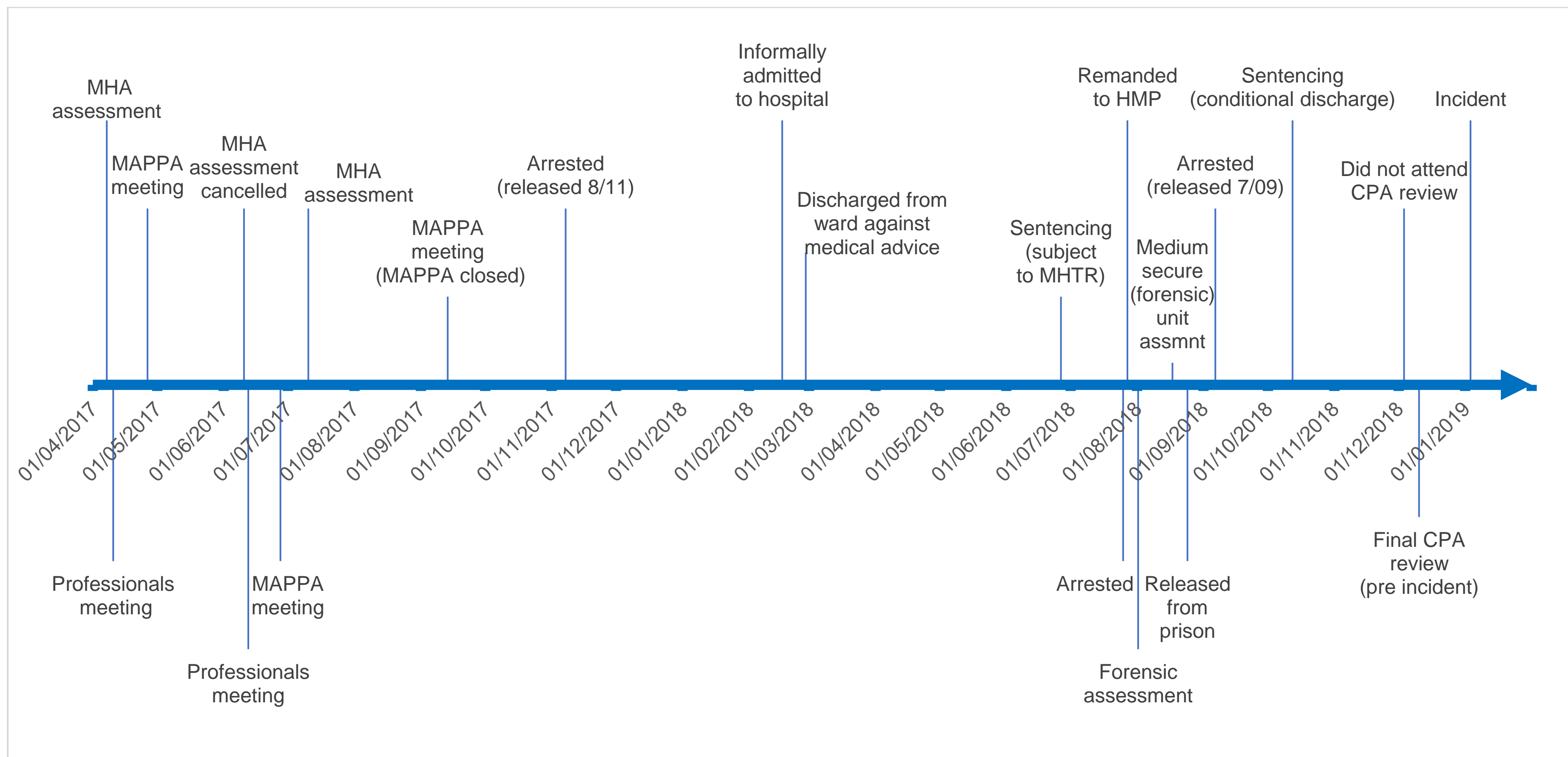
3.90 Mr E missed a physical health check appointment on 17 December 2018.

3.91 Probation Officer 1 wrote to Consultant 1 on 19 December 2018 to advise they had attempted to attend the CPA review on 10 December 2018 but had been given the wrong location details. They added that the conditions of Mr E's MHTR extended to the detail of his CPA reviews being fully disclosed to the probation service. Probation Officer 1 noted that Mr E was engaging minimally with probation. They said Mr E was not eligible for MAPPA because of the nature of his offence: a referral would only be accepted if he posed a significant risk to others, which did not seem to be the case at that time.

3.92 Care Coordinator 1 delivered Mr E's medication to his hostel on 21 December 2018. Care Coordinator 1 did not see Mr E but hostel staff reported no concerns.

3.93 The homicide happened 13 days later in early January 2019. The following diagram provides a summary of the key events that occurred between January 2017 and the incident in January 2019.

Diagram 1: Key events in chronology January 2017 – January 2019



4 Discussion and analysis of Mr E's care and treatment

4.1 In this section we consider Mr E's care and treatment in the context of:

- risk assessment and risk management;
- CPA and care planning;
- MHA and forensic assessments;
- multi-agency engagement;
- conditions of Mr E's MHTR; and
- family engagement.

Risk assessment and risk management plans

4.2 The Healthcare Quality Improvement Partnership (HQIP, 2018)[32] says a good risk assessment combines "*consideration of psychological (e.g., current mental health) and social factors (e.g., relationship problems, employment status) as part of a comprehensive review of the patient to capture their care needs and assess their risk of harm to themselves or other people.*"

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

4.4 Risk management planning is defined as a cycle that begins with risk assessment and risk formulation, which in turn leads to a risk management plan subject to monitoring and review.

4.5 The Department of Health (2009)[33] identifies 16 best practice points for effective risk management which include:

"*… a summary of all risks identified, formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis*"*; and*

"*Risk management must always be based on awareness of the capacity for the service user's risk level to change over time, and a recognition that each service user requires a consistent and individualised approach.*"

[32] HQIP (2018) The Assessment of Clinical Risk in Mental Health Services: https://www.hqip.org.uk/wp-content/uploads/2018/10/Ref-70-Mental-Health-CORP-Risk-Assessment-Study-v0.2.docx.pdf

[33] Department of Health (2009) Best Practice in Managing Risk: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/478595/best-practice-managing-risk-cover-webtagged.pdf

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

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

4.7 The Trust Use of Clinical Risk Assessment Tools (2017, version 4) says a clinical risk assessment should make reference to:

- "*A clear statement about the nature of the harmful outcome to be prevented …*
- *A brief summary of the risk and related protective factors …*
- *A risk formulation …*
- *A risk management plan … linked directly to the risk and protective factors used in the risk formulation …*
- *… the risk management plan will help change the most important risk or protective factors, reducing the potential for harmful outcomes to happen*"

4.8 The policy says risk assessment should ideally be a multidisciplinary undertaking. The policy details points at which risk should be assessed, including when mental state or risk management appears to be deteriorating, or in response to safety concerns.

Mr E's risk assessment and risk management plan

4.9 Care Coordinator 1 updated Mr E's risk assessment on: 4 January 2017, 6 March 2017, 20 March 2017, 5 April 2017, 10 April 2017, 13 November 2017 and 14 February 2018 (seven times). It was also updated by the CJLDT on 21 December 2017 and by ward staff on 27 February 2018 when Mr E discharged himself from the ward. We note in the case of the latter, Mr E's risk assessment was not updated during his admission – only when he discharged himself from the ward.

4.10 Care Coordinator 1 last updated Mr E's risk assessment on 14 February 2018. It documented that Mr E's risk of harm to self had increased and identified indicators in relation to this point (e.g., thoughts of suicide, substance misuse, depressed mood, and major life events). Concerns were documented in relation to Mr E's offending behaviour and violence (e.g.,

actual physical violence and paranoid delusions) and safeguarding adults (e.g., abuse of others). Care Coordinator 1 noted Mr E's psychotic symptoms were increasing and his compliance with medication likely reducing in parallel with increasing drug use.

4.11 Care Coordinator 1 noted that Mr E could potentially be a risk to members of the public: "*Still risk of harm to others due to* [Mr E's] *paranoid thinking and coping techniques if he feels threatened*".

4.12 Mr E's risk assessment was not updated after February 2018 despite a number of incidents which, in keeping with Trust policy, should have prompted an update (e.g., arrests in July and September 2018). Equally Mr E's risk assessment did not reflect the level of detail and consideration of his risk documented by Consultant 1 and Care Coordinator 1 in the clinic letters and progress notes.

4.13 We did not identify a tailored risk management plan in response to the February 2018 risk assessment, rather Mr E had a generic risk management plan (e.g., contact GP or call 999 if unwell). The risk assessment contained a plan ("*summary of assessor's plan for managing my risks and vulnerabilities*") formulated after the April 2017 professionals meeting, the actions for which were completed after the meeting. This section had not been updated to reflect a contemporary plan during or after the risk assessment review in February 2018.

4.14 There is extensive evidence in the notes that CMHT staff were aware of Mr E's risk and the signs that it was increasing. This is evidenced by Consultant 1's clinic letters and Care Coordinator 1's entries in the progress notes. Consultant 1's CPA review letters to Mr E's GP detailed past risk, current risk and a safety plan which extended to signs of relapse, triggers and action Mr E was to take in the event of feeling at risk. We note the CJLDT used the detail of Consultant 1's letters in their own updates and liaison with other teams and services. We also note Consultant 1 sought advice from forensic services in relation to Mr E's risk assessment and management in 2017.

4.15 However, despite Care Coordinator 1 and Consultant 1 having a comprehensive understanding of Mr E's risk, this was not fully reflected in Mr E's risk assessment. Consequently, contemporary information about Mr E's risk was not readily available to other staff who would not necessarily refer to clinic letters (e.g., new CMHT staff). The Trust's internal investigation highlighted gaps in record keeping in relation to risk assessment and risk management; we concur with this finding.

Finding: CMHT staff were aware of Mr E's risks, what increased these, and what steps could be taken to mitigate his risk, but these were not documented in a contemporary risk assessment or risk management plan.

Finding: Mr E did not have a comprehensive risk assessment in place at the time of the incident in January 2019.

Finding: Mr E had a generic risk management plan that was not tailored to his individual risk or updated in response to information or events. This did not reflect the CMHT's understanding of Mr E or their engagement with him.

CPA and care planning

4.16 The CPA is a package of care offered to support mental health service users. It is intended to act as a framework to identify individual needs and goals, with a view to providing support, and is underpinned by a care plan. Care plans can cover a broad number of areas including physical health, medication, housing and social support.[34]

4.17 NICE guidance (2014)[35] says "*People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider*".

4.18 NHS England's *Personalised Care and Support Planning Handbook* (2016)[36] defines personalised care and support planning as:

"*… a process in which the person with a long-term condition is an active and equal partner. The process should normally be recorded in a personalised care and support plan: but this plan is only of value if the process has taken place effectively.*"

4.19 The Care Coordination Association (CCA)[37] defines a care plan as:

"*A plan that describes in an easy, accessible way the needs of the person, their views, preferences and choices, the resources available, and actions by members of the care team, (including the service user and carer) to meet those needs. It should be put together and agreed with the person through the process of care planning and review.*"[38]

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[34] Care For People With Mental Health Problems (CPA): https://www.nhs.uk/conditions/social-care-and-support-guide/help-from-social-services-and-charities/care-for-people-with-mental-health-problems-care-programme-approach/

[35] NICE guidance: https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations#promoting-recovery-and-possible-future-care-2

[36] Personalised Care and Support Planning Handbook: https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf

[37] Care Coordination Association: http://www.cpaa.org.uk/

[38] CCA. Writing Good Care Plans: http://www.cpaa.org.uk/writing-good-care-plans-handbook.html

4.20 The CCA sets out several factors involved in care planning which include:

- "*A systematic review of the needs of the person.*
- *Exploring and discussing choices: to help work out what's the most important, and the implications of different choices.*
- *Goal setting: what do we want to achieve and by whom.*
- *Action planning: what are we going to do, who is responsible, and when will it be reviewed?*
- *Safety: how do we make care as safe as possible?*
- *Support: for someone to manage their own health as much as possible.*"

4.21 The guidance says a care plan should be a written plan of action to meet an individual's health and social care needs, including aims, actions and responsibilities.

4.22 The Trust's Care Programme Approach Policy (2016) identifies criteria for when a service user will require CPA which include a severe mental disorder, current or potential risk (e.g., self-harm and harm to others) and presence of non-physical comorbidity (e.g., substance misuse). It describes a care plan as "*… the Service User's own record of who is involved in supporting their care and recovery. It should promote continuity of care, treatment and support by using effective community between all involved in the Service User's care.*"

4.23 The policy sets out areas (life domains) that should be taken into consideration, as a minimum, when formulating the care plan. These include: managing mental health, living skills, addictive behaviour, accommodation/finances, care involvement and employment. Service users should be fully engaged in the care planning process and offered a copy of their care plan.

4.24 Care plans should be reviewed at least annually, and as required (e.g., in response to significant events). Of note, care plans should be reviewed within one month of discharge from inpatient services.

4.25 The care coordinator is responsible for overseeing the CPA process and ensuring reviews take place. The Trust policy details what steps should be taken in advance of a CPA review and during each review. This includes requesting the views of the service user, carer(s) and other professionals. Where key individuals are unable to attend, they should be asked to provide a written summary. Revised or amended care plans should be shared with the service user, carer(s), advocate and GP.

Mr E's CPA

4.26 Mr E was supported under the CPA and had a care coordinator. There is evidence the CMHT used CPA reviews as a means of trying to engage Mr E, at times in response to events or following concerns being raised by others. For example, an urgent CPA review was arranged in February 2018 in response to Ms A raising concerns and indicating that Mr E might consider a hospital admission. Equally the team rescheduled appointments in response to Mr E missing those originally scheduled. Three CPA reviews took place in 2017, seven in 2018:

- 2017: 20 March, 2 May and 26 June (Mr E missed CPA reviews on 4 October, 2 November and 6 December 2017).
- 2018: 11 January, 14 February, 1 March, 1 May, 16 July, 15 October and 10 December 2018 (Mr E missed CPA reviews on 2 July and 3 December 2018).

4.27 Mr E's last CPA review with Consultant 1 and Care Coordinator 1 took place at his hostel on 10 December 2018. No current risks were identified, though Consultant 1 noted Mr E was underweight. Consultant 1's clinic letter to Mr E's GP provided a summary of recent events and highlighted that Mr E was still subject to an MHTR. The letter described Mr E as having a stable psychotic illness which could be exacerbated by drug use and stress. Relapse signs and triggers were listed. The treatment goal was for Mr E to be drug-free, resolve his accommodation issues and then "*look to the future*". The letter concluded "[Mr E] *appears to be stable in mental health at present with ongoing low level, chronic persecutory ideation which he seems to manage fairly well at present*".

4.28 Consultant 1 and Care Coordinator 1 kept detailed notes of the CPA meetings. There is evidence in the notes that Mr E's GP was invited to contribute to the CPA reviews, either in person or through submitting a written summary. There is also evidence the detail and outcomes of CPA reviews were shared with Mr E's GP, as noted above, sometimes with requests to review and/or change his medication.

4.29 Equally, the CMHT took steps to engage the probation service in the CPA process in 2018, though this was not successfully implemented. We discuss this further in 'External – probation' (paragraphs 4.88 to 4.96).

4.30 Conversely, Ms A told us she was not invited to Mr E's CPA meetings, and she often felt unaware of what had been agreed with regards to his care and treatment. There is evidence that the CMHT was in contact with Ms A about Mr E and they updated the notes to reflect her input as part of the CPA process, but there is no evidence she was invited to attend Mr E's CPA

reviews. We discuss this further in 'Family engagement' (paragraphs 4.124 to 4.147).

Mr E's care plan

4.31 Mr E's last care plan was dated 16 July 2018. The care plan detailed one goal: "*For* [Mr E] *to have reduced negative and positive symptoms and be able to function at a higher level with regards to quality of life with reduced distress*". The plan detailed three actions to help Mr E:

- "*Staff to assist and support me with regards to my diagnosis and risk.*
- *Staff to liaise with my mum to help gain more understanding of my stress levels and triggers.*
- *Staff to gain an understanding of relapse signs* [further detail included]".

4.32 Mr E's care plan provided the contact details of those he should contact in and out of working hours (e.g., the CMHT, his GP, emergency services and various support services).

4.33 Mr E's care plan was not completed in line with Trust policy. Mr E's care plan did not reflect his broader health and social care needs, or the life domains set out in Trust policy, for which there is an expectation that all will at least be considered during a CPA review. The exception to this was managing Mr E's mental health, but we do not consider the detail included to be sufficient.

4.34 In the context of Mr E's mental health and wellbeing, we detail below the care plan domains documented in Trust policy and cross reference these with aspects of Mr E's health, wellbeing and lifestyle which we believe should have been taken into consideration in relation to these domains.

Table 2: Trust care plan life domains cross referenced with Mr E's wellbeing, lifestyle and behaviour

Care plan life domain (Trust policy)	Mr E
Managing my mental health	This is briefly addressed in Mr E's care plan.
Self-care/living skills	Mr E was often noted in the progress notes to have poor self-care and neglect. Ms A reported she had to remind him to wash.
Education/training/employment	Mr E was unemployed and there is no evidence further education or employment were explored with him.
Addictive behaviour	Mr E was known to use crack cocaine and heroin. Engaging with addiction services

Care plan life domain (Trust policy)	Mr E
	was discussed with Mr E but this was not reflected in his care plan. Consultant 1 considered Mr E's drug use to be a key factor in his presentation and management.
Identity, self-esteem, trust and hope	Ms A told the CMHT in October 2017 and January 2018 that Mr E was suicidal.
Accommodation/finances	Mr E had unstable accommodation and in September 2018 hostel staff informed Care Coordinator 1 that Mr E was to be given a 28-day eviction notice. Historically he had experienced periods when he had no fixed address.
Social networks/relationships	Mr E was noted to have a volatile relationship with his partner. Additional stresses were documented by the CMHT about his family relationships.
Physical health	Ms A told Care Coordinator 1 in September 2017 that Mr E had received treatment for an infected stab wound in the chest (he attended A&E for treatment). She also had concerns about a wound he had sustained to his foot. Ms A told us that he was extremely thin between 2017 and 2019 (Consultant Forensic Psychiatrist 2's forensic report in August 2018 described Mr E as "*unusually thin for someone on 20mg olanzapine*"). Consultant 1's clinic letters detailed actions for Mr E's GP e.g., ensuring he was receiving yearly health checks.
Caring responsibilities	CMHT staff were aware of concerns in relation to this domain in July 2018. The matter did not continue, and we do not provide further detail in the interest of confidentiality.
Carer involvement	Mr E's mother was in regular contact with the CMHT about his wellbeing and health.

4.35 There were aspects of Mr E's life that should have been considered against each of the life domains identified in Trust policy. His care plan should have adopted a biopsychosocial approach, reflecting the different domains. Instead, Mr E's July 2018 care plan was limited to his mental health and lacked detail in terms of meaningful intervention. For example, the care plan placed emphasis on CMHT staff providing Mr E with assistance and support but did not detail a structured approach to helping Mr E to have "*reduced negative and positive symptoms …*"

4.36 There is evidence Care Coordinator 1 and Consultant 1 were trying to support Mr E beyond his immediate mental health needs, but this is not reflected in his care plan. For example, Care Coordinator 1 had engaged a social worker to support Mr E in relation to his accommodation and benefit needs and Consultant 1 had provided a letter to support Mr E's PIP application in October 2018. Mr E's care plan did not reflect the CMHT's broader care and treatment plan for him, nor was it updated after CPA reviews or after he left hospital in February 2018.

4.37 We note a care plan for Mr E dated 11 January 2018 contained more detail in relation to assertive action and broader consideration of Mr E's lifestyle (e.g., Waves of Hope to be contacted for help with accommodation). We cannot account for this variation in record keeping. The Trust's internal investigation was critical of the detail recorded in Mr E's care plan; we concur with this assessment.

Mr E's treatment plan

4.38 The CMHT's long-term plan for Mr E was:

- detention under Section 3 MHA for inpatient treatment;
- assessment by forensic services to review his care pathway;
- a sustained period of admission to improve Mr E's insight and reduce his illicit substance use;
- consideration of depot or clozapine; and
- treatment under a CTO upon discharge from hospital.

4.39 However, the above was not reflected in Mr E's care plan in the context of aims to achieve these goals. It was documented in the progress notes and in clinic letters, but there is no evidence Mr E was aware of his intended treatment, nor was a plan developed with him in relation to these points.

4.40 Mr E was not detained under the MHA in 2017 or 2018 and was subject to only a brief informal admission in February 2018 (a forensic assessment was not mobilised in this time). The team had no legal grounds to compel Mr E to

take his medication and he was clear that he did not wish to receive depot medication.

4.41 Despite these barriers, Mr E's treatment plan remained largely unchanged throughout the period of review. We asked Consultant 1 what options were available to the team given Mr E was not detained under the MHA. Consultant 1 told us there were limited options because the team could not compel Mr E to accept treatment, but were reliant on his engagement, which varied extensively. He was subject to an MHTR in the latter part of 2018 – we discuss this further in 'MHTR' (paragraphs 4.107 to 4.123).

Finding: The CMHT appropriately arranged CPA reviews in response to changes in Mr E's behaviour and/or concerns identified by the CMHT or third parties (e.g., Mr E's mother).

Finding: Mr E had a care plan that was in date at the time of the incident, but it was not completed in line with Trust policy and lacked sufficient breadth and detail to facilitate meaningful treatment. It did not reflect the CMHT's intended treatment plan for Mr E.

Finding: The CMHT had limited recourse to engage Mr E in treatment. He was not subject to a legal framework and his participation in care and treatment was voluntary.

Finding: The CMHT considered Mr E warranted a period of assessment and treatment in hospital, possibly followed by treatment in the community under a legal framework (e.g., a CTO). The team made arrangements for Mr E to be assessed under the MHA twice in 2017, with a view to him being assessed and treated in hospital, but he was not considered to be detainable on either occasion.

Mental health assessments

MHA assessments

4.42 An MHA assessment is undertaken to establish whether an individual should be detained in hospital for assessment (Section 2 MHA) and/or treatment (Section 3 MHA). Practitioners are required to consider the nature and degree of the service user's mental health and if either warrant detention for assessment or treatment. 'Nature' refers to the service user's mental disorder, "*its chronicity, its prognosis, and the patient's previous response to receiving treatment for* [the] *disorder*". 'Degree' refers to the "*current manifestation of the patient's disorder*".[39]

[39] MHA 2007 Explanatory Notes: https://www.legislation.gov.uk/ukpga/2007/12/notes/division/6/1/1/5?view=plain

4.43 An MHA assessment is carried out by an AMHP, a Section 12 approved doctor and another doctor.

4.44 In March 2017, the CMHT and Ms A raised concerns about Mr E's mental health and whether his risks could be managed safely in the community. There were concerns Mr E was storing weapons and that he was displaying signs of possible relapse. Mr E was initially deemed to be manageable in the community, but in April 2017 Consultant 1 was of the view Mr E would benefit from a sustained period of treatment in a secure inpatient setting. The CMHT made arrangements for an inpatient admission, with a view to Mr E being admitted under Section 3 MHA. An MHA assessment was undertaken on 7 April 2017 and took one hour. Mr E was not deemed to be detainable.

4.45 An MHA assessment (with the police in attendance) on 10 June 2017 did not take place because Mr E could not be located.

4.46 A second MHA assessment for detention under Section 3 of the MHA was undertaken on 10 July 2017, and again Mr E was assessed as not detainable. The length of the assessment was not documented in the notes.

4.47 We have reviewed the AMHP reports from both assessments and have no concerns in relation to their content. Both are detailed and the rationale for the decisions made is clearly documented. There is clear evidence that Mr E's risk history was known and a detailed risk profile is set out. We note minor errors in the April 2017 AMHP report (e.g., the date is recorded as April 2016 and details of the two doctors are absent), but we have no concerns in relation to the detail of the documented assessments, both of which are of good quality. We note Ms A was also of the view that Mr E was not detainable prior to the assessment in April 2017.

4.48 The CMHT does not have an AMHP attached to the team, rather they have to contact the Trust AMHP service. We discussed with Consultant 1 and Care Coordinator 1 whether this was a barrier for the team in terms of assessments being undertaken by AMHPs who knew the patients and their history. Both said that whilst it would likely be helpful to have AMHPs familiar with the service users, they could not comment as to whether it would have altered the outcome of either assessment (Consultant 1 concluded during the July 2017 assessment that Mr E was not detainable). It is possible that if AMHPs were integrated into CMHTs it might have been easier to manage the MHA assessments as part of Mr E's long-term care, and to consider the case for detention on the basis of 'nature' instead of 'degree' of mental illness, however, we accept this is speculative and not the Trust model.

4.49 Consultant 1 told us there were often mixed views about whether Mr E could be detained. Mr E's presentation fluctuated and could change quickly. Consultant 1 cited an example of when they considered him to be detainable, but his presentation had changed entirely by the point of assessment which

was therefore not undertaken. Consultant 1 told us that the more they got to know Mr E, the more they were of the view he needed a period of inpatient treatment, based on the nature, if not the degree, of his illness. Consultant 1 believed Mr E would benefit from treatment possibly in a secure setting, followed ideally by a CTO upon discharge, to facilitate compliance with treatment.

Finding: Mr E was subject to two MHA assessments in April and July 2017. He was not deemed to be detainable on either occasion.

Forensic services

4.50 Consultant 1 requested input from Trust forensic services in relation to the management of Mr E in March 2017. Consultant 1 also asked for help in devising a risk assessment and risk management plan for Mr E. Following discussion with the team, it was agreed (detailed in a letter sent by Specialist Trainee 1 on 5 April 2017):

- Mr E should be subject to an urgent MHA assessment;
- Mr E should initially be admitted for assessment on the PICU; and
- Mr E would be seen by the forensic team for assessment and completion of an HCR-20[40] assessment to determine his future care pathway.

4.51 Forensic services would only assess Mr E if he was admitted to hospital. As noted above, Mr E was not deemed to be detainable under the MHA in April 2017. Consultant 1 wrote to the forensic service on 10 April 2017 after the assessment saying:

"*I remain of the opinion that* [Mr E] *would be best managed in hospital in order to establish him securely on medication, preferably in depot form, to consider a more secure setting, possibly for the administration of clozapine, to arrange a suitable supported accommodation and to risk assess carefully in conjunction with the family.*"

4.52 The joint plan remained but Mr E was not detained after a second MHA assessment in July 2017.

4.53 Consultant 1 wrote to Consultant Forensic Psychiatrist 1 in November 2017 to ask if the forensic service was able to provide any advice in relation to the management of Mr E. Consultant 1 queried whether there were any elements of Mr E's risk management that the CMHT had not addressed, noting he had recently been taken off MAPPA because it was felt there was nothing further that could be added in relation to risk management. We did not identify any

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[40] HCR-20: Historical Clinical Risk Management-20 is a violence risk assessment tool used by forensic services.

further correspondence between Consultant 1 and forensic services until February 2018 when Mr E was informally admitted (the evening of 16 February 2018). Consultant 1 contacted the forensic team on 19 February 2018 to request an assessment for Mr E. However, forensic services replied a week later on 26 February 2018 to advise that the original referral had been closed due to the time that had passed and a new referral would need to be submitted. A forensic assessment was not undertaken prior to Mr E discharging himself from the ward on 27 February 2018. The lack of timely response by forensic services to Consultant 1's request meant there was a missed opportunity to undertake a forensic assessment with Mr A in February 2018. Equally whilst the team indicated a willingness to assess Mr E, this was subject to another referral being received from Consultant 1. An assessment was not proactively arranged in anticipation of receipt of the referral, despite the dialogue in 2017 between Consultant 1 and the forensic service about Mr E's treatment plan and managing his risk.

4.54 The Trust does not have a commissioned forensic offer for community-based service users (i.e., a preventative offer). The exception to this is that forensic services are commissioned to follow up with service users who are returning to the community from an inpatient secure setting: forensic services offer a step down service. Mr E was not eligible for forensic support in the community because he had not received treatment in a secure setting.

4.55 It is our view that the lack of access to a forensic assessment in the community was a barrier to Mr E's assessment and treatment. He had been found not to be detainable under the MHA twice and Consultant 1 continued to request advice from the team about his management, but a solution beyond this was not forthcoming. A forensic assessment could have identified different immediate and long-term approaches to managing Mr E's risk and helped facilitate an understanding of the relationship between his mental health and offending behaviour. Consultant 1 told us they considered Mr E a high-risk patient who would have benefitted from forensic oversight in the community.

4.56 Mr E was subject to a forensic assessment by Consultant Forensic Psychiatrist 2 in August 2018 whilst on remand in prison for possession of an offensive weapon. The assessment concluded that Mr E did not meet the threshold for detention under Sections 48[41] and 49[42] MHA and did not require transfer from prison to a secure hospital setting. Consultant Forensic Psychiatrist 2 detailed nine points in relation to this conclusion, which included that Mr E appeared to be compliant with his medication and was not taking illicit substances. Consultant 1 described this to us as "*frustrating*" in the sense they felt Mr E would have benefitted from a period of detention under

[41] Section 48 MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/48

[42] Section 49 MHA: https://www.legislation.gov.uk/ukpga/1983/20/section/49

the MHA, but they understood Mr E's presentation had changed, noting a prison setting would likely have improved Mr E's compliance with his medication and he would have had less access to illicit substances (thereby improving his mental health). Consultant 1 told us his presentation changed when he left prison – his compliance with his medication was in doubt and he started taking illicit substances again. Consultant 1 remained of the view that Mr E needed a sustained period in hospital for assessment and treatment.

Finding: Consultant 1 proactively sought input from forensic services in relation to the management of Mr E's risk.

Finding: In 2017 forensic services agreed to review Mr E if he was admitted to an inpatient setting. Mr E was not admitted in 2017 and consequently he was not assessed by forensic services.

Finding: The forensic service did not respond in a timely manner to Consultant 1's request to assess Mr E when he was admitted in February 2018, despite discussions with the service about Mr E in 2017.

Finding: The Trust does not have a community-based forensic assessment function for service users who have not previously been subject to a secure services admission.

Finding: Community teams' access to input/advice from forensic services is based on local, informal arrangements.

Internal teams and external agency working

4.57 The CMHT liaised with a number of internal teams and external agencies as part of its management of Mr E's care and treatment. We note Ms A was critical of inter-agency engagement, describing a failure on the part of all the agencies to take responsibility for actions and/or ensure agreed steps were implemented. We detail below the CMHT's engagement with internal teams and external agencies.

Internal – CJLDT

4.58 The CJLDT service specification (2015) says it seeks to "*… provide a high quality through care service for service users with mental disorder, at any point of arrest across police stations, and proceeding through courts, prison establishments and probation environments*". The service aims include:

- "*provide a gateway to primary and secondary mental health services through CJLDT.*"
- *Provide an early point of access within the* [criminal justice system] *(i.e., at the point of arrest at a police station) for detainees to be considered in need of mental health assessment and intervention.*

- *To enable detainees with mental disorder and other vulnerabilities to have equitable access to care within the criminal justice system.*

- *To respond to and intervene appropriately to identify detainee's needs when in an acute psychiatric emergency (i.e., organise Mental Health Act assessments)."*

4.59 The CJLDT liaises with agencies including members of MAPPA, prisons, magistrate and Crown Courts, and probation. The service specification details high, medium and low priorities. High priorities include MHA assessments in police custody and court, and service user follow up in court.

4.60 There is evidence of good communication and working relations between the CMHT and CJLDT in relation to Mr E. The CJLDT attended the three MAPPA meetings and a professionals meeting about Mr E in 2017. The notes indicate they implemented actions assigned to them (e.g., contact the police to confirm what markers were in place for Mr E). Equally, the CJLDT responded to Consultant 1's request in December 2017 to assess Mr E under the MHA, though on the day it was concluded an MHA assessment was not needed. The notes detail a broad assessment on 21 December 2017 which considered Mr E's offending behaviour and risk, support networks, housing, employment and education and mental state examination. Consultant 1 described the CJLDT to us as "*good*" and "*very reliable*".

4.61 The CJLDT saw Mr E after his arrest in July 2018 and during subsequent court appearances. The notes indicate the team was liaising with Mr E's legal team and the CMHT during this period. However, we note that there were gaps in communication in relation to Mr E's MHTR, specifically the detail of the conditions. The CJLDT informed Consultant 1 that Mr E had received an MHTR, but were unable to provide the detail, instead directing her to contact the probation service. The CJLDT Standard Operating Procedure (SOP) indicates the CJLDT, not the CMHT, was best placed to undertake this task and should have done so.

4.62 Ms A was critical of the CJLDT's assessment of Mr E after the offence in January 2019, but we cannot comment because this extends beyond our terms of reference.

Finding: The CJLDT acted in line with Trust policy in its liaison with the CMHT and management of Mr E's engagement with criminal justice services.

Internal – ward (February 2018)

4.63 Mr W was informally admitted to an acute ward at the Trust on 16 February 2018. Mr E remained on the ward, with periods of leave, until 27 February 2018 when he discharged himself against medical advice.

4.64 The notes detail Consultant 1's expectations for assessment and treatment if Mr E were to be admitted. There is evidence the CMHT was in contact with the ward in relation to Mr E's admission and signposted them to details of Consultant 1's assessments in the notes. Mr E's admission notes documented the plan "*as per* [Consultant 1's]" e.g., to consider whether Mr E would benefit from a trial of clozapine. In addition, Care Coordinator 1 attended a ward round on 19 February 2018 and told staff that Mr E could mask his symptoms.

4.65 However, there is no evidence the ward team implemented Consultant 1's plan prior to Mr E discharging himself from hospital. Of note, the ward did not contact forensic services to request an assessment. The Trust internal report was critical of the lack of a treatment plan for Mr E whilst on the ward, but we identified a care plan that commenced on 16 February 2018. It was updated daily up to and including 19 February 2018. The treatment plan did not fully reflect the CMHT's assessment and treatment intentions for Mr E but did include the aim "*to help promote abstinence from illicit substances in the community*".

4.66 On 20 February 2018 it was recorded in the notes that if Mr E attempted to leave the ward he should be placed under Section 5(4) and/or Section 5(2). We note the pre-emptive nature of this recommendation; however, service users can only be detained based on their presentation at the time of an assessment by the nurse in charge or relevant clinician (not by an earlier instruction in the notes).

4.67 The ward discharge summary was not sent to Mr E's GP until July 2018 over four months after he had left the ward. A discharge notification was sent to the GP on the day of discharge, but this contained less information than the discharge summary. However, the information in the summary provided was out-of-date given the time that had passed (e.g., his olanzapine prescription had increased). It should have been sent to Mr E's GP shortly after Mr E left the ward.

Finding: CMHT staff liaised with the ward in relation to Mr E's care and treatment in February 2018. The ward did not implement the CMHT's treatment plan prior to Mr E discharging himself from the ward against medical advice.

External – MAPPA

4.68 MAPPA are processes by which the police, probation and prison services, with other agencies, manage violent and sexual offenders based in the community. It was agreed at a professionals meeting on 10 April 2017 that Mr E should be referred to MAPPA.

4.69 Mr E was subject to MAPPA between April and September 2017, at:

"*Level 2: Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multi-agency public protection meetings about the offender.*

Category 3: Other dangerous offenders who have committed an offence in the past and are considered to pose a risk of serious harm to the public."[43]

4.70 MAPPA guidance states Category 3, level 2 offenders can be discharged from MAPPA when "… *the risk of harm has reduced significantly or the case no longer requires active multi-agency management.*"[44]

4.71 The police were the lead agency for Mr E's case. MAPPA panel meetings took place on 26 April (when he was considered a very high risk to others), 27 June and 13 September 2017. The meetings were attended by representatives from the police, CJLDT, Consultant 1 and Care Coordinator 1. The meeting notes also reflected input from Ms A although we assume this is through feedback to the CMHT.

4.72 The final MAPPA meeting was attended by the above, and the CCG safeguarding lead, the local authority housing coordinator and a representative from the probation service, although it was noted Mr E was no longer on probation.

4.73 We note between June and September 2017:

- Two MHA assessments were arranged (with the police in attendance) but then cancelled in June 2017 because on one occasion Mr E did not attend his scheduled CPA review, and on the second, he could not be located.
- It was noted at Mr E's CPA review on 26 June 2017 that he had been stopped three times by the police, but not arrested.[45]
- It was noted at the June 2017 MAPPA meeting that Mr E had admitted to Care Coordinator 1 he was only taking half his medication.
- Mr A was subject to an MHA assessment on 10 July 2017 (but not detained).
- Ms A reported on 4 September 2017 that Mr E had an infected stab wound in his chest. Care Coordinator 1 later recorded in the notes that there was no police activity in relation to Mr E being stabbed.

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[43] MAPPA categories and levels: https://mappa.justice.gov.uk/MAPPA/view?objectID=18828016

[44] MAPPA guidance: https://mappa.justice.gov.uk/connect.ti/MAPPA/view?objectID=64498149

[45] A custody mental health alert was in place at this time but was not activated because Mr E was not arrested.

4.74 The point above indicates that there were ongoing concerns in relation to Mr E, but the meeting notes do not reflect these concerns (e.g., the notes do not reference the stabbing reported by Ms A).

4.75 However, the meeting notes indicate the CMHT said Mr E had presented as stable during the July 2017 MHA assessment and that Ms A had reported to them that he had started to settle and had no current concerns. Mr E's olanzapine had been reduced to manage his previous halving of the dose. Mr E was noted to be maintaining phone contact and had attended some of his informal appointments, but his attendance was voluntary, and he was not obliged to attend. It was reported that if Mr E failed to attend any appointments with the CMHT over a six-month period he would be discharged from the service because of his informal status (i.e., he was not subject to any legal frameworks or a conditional discharge). Mr E's last appointment with the CMHT was noted to be chaotic, largely because he had attended with a pit bull which had led to a discussion with security staff, and a member of the public who Mr E accused of hitting the dog. Mr E was agitated but did not present as paranoid.

4.76 Similarly, the police updated the meeting that they had attended reports of a stabbing on 8 September 2017 but Mr E told them he had stepped on a broken nail varnish bottle and only said he had been stabbed so an ambulance would attend (Mr E's foot was wounded). Mr E showed no signs of aggression or paranoia and the incident was classed as a verbal argument between Mr E and his partner. No other concerns were identified.

4.77 The meeting summarised Mr E should continue to be considered high risk:

"[Mr E] *is currently presenting as medium risk, however due to the* [lack of] *protective factors involved with his mental health, accommodation and drug use there is potential for him to cause harm. The panel agreed that even though he is bordering between medium and high, it is best to leave him as high risk due to the* [lack of] *protective factors.*"

4.78 Mr E's risk framework completed on 13 September 2017 categorised Mr E's risk of serious harm to be high.

4.79 However, it was noted Mr E's engagement with any service was voluntary and he was not on licence. Mr E was discharged from MAPPA in September 2017 because all previous MAPPA actions had been completed, no new risks had been identified, and it was deemed there was no further value for Mr E to remain subject to MAPPA unless his risk increased. The meeting minutes do not indicate any concerns on the part of the meeting attendees in relation to this decision. It was noted Mr E would be brought back to MAPPA if required.

4.80 There is no evidence in the notes that professionals considered a referral to MAPPA in November 2017 when Mr E was arrested for carrying a bladed

article. Mr E was referred again to MAPPA in October 2018, on the advice of the August 2018 forensic assessment, but this was initially delayed due to confusion as to whether prison services had actioned the referral, and then due to an administrative error. As a result the referral had not been processed prior to the incident in January 2019.

4.81 The Trust uses H-RAMM for service users it considers to be high risk but who do not warrant MAPPA. The Trust policy (2018) describes the aim of H-RAMM as:

"*… to manage risk posed by individuals to the public, including previous victims from serious harm. H-RAMM is designed to support* [Trust staff] *to manage service users whose risk excels management under CPA but do not meet the criteria for risk management under MAPPA.*"

4.82 H-RAMM was considered for Mr E after he was discharged from MAPPA in September 2017. The Trust internal report highlighted Trust-wide low use of H-RAMM. We asked Care Coordinator 1 why H-RAMM was not considered for Mr E. They told us when they had previously referred Mr E to H-RAMM in March 2017, this had been rejected by the CJLDT[46] who were responsible for triaging H-RAMM referrals, therefore they did not consider it an option for Mr E going forward.

4.83 Consultant 1 told us that because Mr E had previously been subject to MAPPA and because in late 2018 they thought another MAPPA referral was being processed, a referral to H-RAMM would not have been appropriate (service users are only referred to one). It was only at Mr E's December CPA meeting that Consultant 1 realised the referral to MAPPA had not been completed. Consultant 1 told us they did refer service users to H-RAMM, and they may have considered it for Mr E had the MAPPA referral been rejected and the offence not happened.

Finding: Mr E was appropriately subject to MAPPA between April and September 2017. He was closed to MAPPA in September 2017 due to all actions being implemented and no new risks being identified, however, Mr E was still considered to be high risk. All services involved at the time, including the Trust, agreed with this decision. It is our view that it would have been helpful to have kept Mr E on MAPPA beyond six months, with a view to assessing whether his period of relatively stability could be maintained, particularly as there had been incidents in the preceding months which indicated concerns in relation to his mental health and wellbeing.

[46] It was documented by a member of the CJLDT that Mr E's risks appeared to be historical, and it was unclear if his risks were increasing. It was concluded Mr E could be managed within a CPA risk meeting. The CMHT subsequently arranged a professionals meeting.

Finding: A further referral was recommended, as part of the forensic assessment, in August 2018. However, an administrative error meant the referral was not processed in a timely manner, and not before the incident in January 2019.

External – HMP

4.84 Mr E was remanded in custody on 27 July 2018 for possession of an offensive weapon whilst subject to a 10 month suspended sentence. The notes indicate Consultant 1 liaised with prison services in relation to her concerns about Mr E being in custody and his risk management; they emailed and telephoned on 30 July 2018. Consultant 1 queried whether a mental health alert had been raised for Mr E in relation to being high risk for suicide; the alert was forwarded to the prison Integrated Mental Health team (IMHT). Consultant 1 said that Mr E could mask his symptoms, his risk had recently been increasing in the community and that he needed further assessment in a hospital setting. Mr E was referred to the IMHT and allocated a care coordinator. The IMHT submitted an urgent request the same day for Mr E to be assessed by a psychiatrist.

4.85 Mr E was seen by Consultant Forensic Psychiatrist 3 on 1 August who concluded Mr E warranted further assessment and more information was needed from Consultant 1, whom he subsequently liaised with. They agreed that Mr E should be referred to medium secure services and an urgent referral was submitted on 2 August 2018. Consultant Forensic Psychiatrist 2 assessed Mr E on 17 August 2018. He concluded Mr E did not warrant admission to secure services.

4.86 Mr E was not transferred to the prison inpatient unit whilst on remand (previously suggested by Consultant 1). Mr E informed his prison care coordinator on 21 August that he would not move, and it was concluded at the IMHT team meeting later the same day that Mr E was settled and that any move would cause him undue stress. It was agreed he would continue to receive support from the IMHT.

4.87 Mr E was released on the afternoon of 24 August 2018. The CJLDT informed the IMHT and CMHT. The CMHT notes indicate Mr E's release on a Friday afternoon was possibly unexpected[47] and the team was unable to assess Mr E's need for stepped up care over the weekend and had been unable to contact Ms A to clarify where he would be staying.

4.88 Mr E's IMHT care coordinator sent a referral to the CMHT on 30 August 2018 (there is no information in the notes to suggest Mr E had been discharged from the CMHT). The referral detailed Mr E's mental health history, his time in

[47] The CMHT notes indicate the CJLDT had advised the CMHT on 23 August 2018 that Mr E was attending court the next day but the notes do not say whether this was to review his sentence and/or possible release.

prison, physical health, substance misuse and medication. The letter highlighted Mr E's risk, as detailed in the August forensic assessment report. The referral said Mr E's risk management should be multi-agency and highlighted the role of his substance misuse in exacerbating his risk and psychotic symptoms. The forensic assessment report, Mr E's prescription care and SystmOne (prison health) records were attached to the referral. The referral signposted the reader to the detail of Mr E's last contact with his IMHT care coordinator on 21 August 2018 in the prison notes. The referral did not say whether any of the forensic assessment report recommendations had been actioned. The referral was copied to Mr E's GP.

4.89 The IMHT had not referred Mr E to MAPPA and had not referred him to Shelter[48] in preparation for his release. The CMHT referral documented that Mr E intended to stay with his brother upon release; there is no evidence in the IMHT notes to indicate when this was discussed with Mr E.

Finding: Consultant 1 proactively liaised with prison services about Mr E's risks and management following his remand in July 2018. This was good interagency engagement by Consultant 1, ensuring prison services were fully informed about Mr E's risks.

Finding: Mr E was promptly referred to the prison mental health services (IMHT), had a care coordinator and an initial care plan. The IMHT acted promptly on Consultant 1's recommendations and arranged an urgent forensic assessment for Mr E. This was good practice. The notes indicate the IMHT regularly reviewed Mr E's risk to self and others.

Finding: The IMHT provided a detailed referral to the CMHT when Mr E was released in August 2018. However, the CMHT received no warning that Mr E was to be released from prison, which meant they were not prepared for his release and were unable to put arrangements in place to manage his return to services. The nature of the IMHT referral meant the CMHT was unclear as to what recommendations from the forensic service assessment had been implemented (e.g., referral to MAPPA).

External – National Probation Service

4.90 There was no information sharing agreement between the Trust and the probation service when Mr E received an MHTR as part of his sentence in 2018. However, there was guidance in place that highlighted the importance of the NHS and partner agencies working together to deliver MHTRs (e.g.,

[48] Shelter: A housing and homeless charity https://england.shelter.org.uk/

Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery).[49]

4.91 We identified some communication between the CMHT and probation service. For example, Probation Officer 1 wrote to Consultant 1 in July 2018[50] to introduce themselves as Mr E's offender manager. They asked to be invited to Mr E's CPA meetings. The letter did not include detail about the conditions of Mr E's MHTR.

4.92 Care Coordinator 1 called the probation service on 29 August 2018 to discuss Mr E's release from prison – they left a message asking Probation Officer 1 to call them back. Care Coordinator 1 met Probation Officer 1 by chance later the same day when they went to give Mr E his medication at the hostel and Probation Officer 1 was present. The probation service told us that Probation Officer 1 would have returned Care Coordinator 1's phone call had they not met at the hostel.

4.93 Probation Officer 1 was invited to Mr E's October CPA meeting, but they were unable to attend. However, there is no evidence Probation Officer 1 was formally invited (in writing) to Mr E's 3 December 2018 CPA meeting (which did not take place because he did not attend) or the rescheduled meeting on 10 December 2018. The notes indicate the team understood Mr E had invited Probation Officer 1 to the rescheduled meeting but had mistakenly given Probation Officer 1 the wrong venue (which had been changed at short notice). Consultant 1 told us it had been the team's intention that Probation Officer 1 attend Mr E's CPA reviews and it was an administrative error that they had not been routinely invited.

4.94 Consultant 1 sent an abridged (at Mr E's request) clinic letter to Probation Officer 1 on 11 December providing a summary of the previous day's CPA review. Probation Officer 1 wrote back on 19 December 2018 to inform Consultant 1 that they had tried to attend the meeting but had been given the wrong details. In addition, in keeping with the conditions of Mr E's MHTR, they should be fully informed of the CPA review outcomes. The letter indicated the probation service had concerns about Mr E's engagement with them but made no comment in terms of next steps should Mr E continue to not engage with services.

4.95 We did not identify any further communication between the CMHT and probation service.

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[49] National Offender Management Service (2015) Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

[50] The letter is undated but was received by the CMHT on 30 July 2018.

4.96 The nature of communication between the two agencies was sporadic and was inconsistent at the time of the incident, despite Mr E receiving an MHTR several months previously. It is our view that it would have been good practice for the two agencies to have worked together to agree a strategy at the outset to monitor and communicate any concerns in relation to Mr E's adherence to the conditions of his MHTR.

4.97 We discuss engagement between the two agencies in further detail in 'MHTR' (paragraphs 4.107 to 4.123).

4.98 The probation service has since developed guidance (2019) which it has shared with the Trust entitled Guidelines for Probation Staff for the Recommendation of a Mental Health Treatment Requirement as Part of a Community Order/Suspended Sentence.[51]

Finding: The CMHT and probation service did not agree an approach for working together to monitor and manage Mr E's adherence to the conditions of his MHTR. There was limited communication between the two agencies.

Mr E's drug use

4.99 Studies have indicated that much of the elevated risk associated with service users who have a diagnosis of schizophrenia and use illicit substances can be attributed to their drug use rather than their mental illness.[52]

4.100 The Trust's Management of Service Users Who Have Coexisting Problems Related to Illicit Substance/Alcohol Use Policy (2015) defines dual diagnosis as:

"*… to denote a Service User who has both a mental health problem and a substance misuse/alcohol problem (which may or may not have been diagnosed) which require some form of intervention. Frequently further clinical conditions and social problems exist.*"

4.101 It goes on to say:

"*If a Service user is identified as having a Dual Diagnosis, then further assessment/discussion should consider the risks associated with commonly associated problems/behaviours:*

- *Aggression/violence – involvement with criminal justice system*

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[51] The probation service also provided an action plan created after the incident in January 2019. This includes "*To ensure the effective delivery of Mental Health Treatment Requirements*" and sets out 7 actions some of which involve health services. Our terms of reference do not extend to reviewing this action plan.

[52] Baird A, Webb RT, Hunt IM, Appleby L and Shaw J. Homicide by men diagnosed with schizophrenia: national case-control study. *British Journal of Psychiatry.* 2020; 6:e143, p1-8.

- *Suicidality*
- *Safeguarding issues*
- *Accommodation/homelessness*
- *Family difficulties*
- *Financial difficulties*
- *Increased incidences of Blood born Viruses and other Physical Health Care Deficits.*"

4.102 The policy advises that a full drug and alcohol history be taken from the service user, and lists factors to be considered (e.g., frequency, amounts, last use, and whether taken alone or with others). The policy advises that clinicians consider the service user's drug and alcohol use when formulating care plans or risk management plans. Clinicians are further advised to consider referring the service user to specialist addiction services. In instances when a service user declines such services "*… the risks associated with the current position should be considered and monitored regularly*".

4.103 It is documented throughout Mr E's notes that he used cannabis, crack cocaine and heroin (e.g., he tested positive for the latter two after his arrest on 6 September 2018). During his inpatient admission in February 2018, he was noted to smell of cannabis when returning to the ward after leave. Consultant 1 told us they considered Mr E's drug use to be a key factor in exacerbating his symptoms. Care Coordinator 1 and Ms A held similar views. When we met him, Mr E confirmed that he had regularly used drugs in the past.

4.104 We have previously documented that Mr E's care plan (July 2018) lacked sufficient detail and breadth to facilitate meaningful treatment. Mr E's drug use is referenced in the context of being an indicator of relapse – it is not explored as a separate entity and there are no associated aims/goals in relation to reducing his drug use. Equally there is no evidence a detailed assessment was undertaken in relation to his drug use, as guided by the policy detailed above. However, the CPA clinic letters did reflect an ongoing intention that Mr E try to reduce his drug use. Equally, the notes detail that Care Coordinator 1 had tried to encourage Mr E to engage with addiction and support services (e.g., appointments with a local charity), but he had declined.

4.105 Care Coordinator 1 told us they did not think Mr E was motivated to address his drug use. He said the team tried to help Mr E engage with addiction services, but he appeared reluctant.

4.106 Consultant 1 told us they had been hoping and expecting that Mr E would receive a DRR as part of his sentence in June 2018 (as per their

recommendations to the court). However, this recommendation was not accepted by the court and Mr E received a RAR. The CJLDT later advised Consultant 1 that this was likely due to the nature of the index offence, but drug work would be included as part of the RAR. Consultant 1 told us a DRR might have been helpful in managing Mr E, though it was still reliant on him engaging in treatment. Probation Officer 1's letter to Consultant 1, dated 19 December 2018, detailed that Mr E was not engaging with probation and they thought it likely he was using drugs, though Mr E had said he had not done so for a number of months. Probation Officer 1 reported they had referred Mr E to addiction services, but he declined to engage.

4.107 The Trust does not have a dual diagnosis service, drug services are separate to mental health services. Consultant 1 told us a dual diagnosis might have provided the team with more opportunities to engage Mr E in relation to his drug use, but again, this would have been reliant on his willingness to engage with services.

4.108 The Trust is taking steps to embed dual diagnosis expertise within the CMHTs and has developed a local division addictions/dual diagnosis steering group. The Trust is currently appointing dual diagnosis advocates to each CMHT.

Finding: Mr E routinely used illicit substances which were known to exacerbate his symptoms of paranoia and poor mental health. The CMHT took steps to help Mr E engage with addiction services, but his engagement was voluntary, and he declined to attend appointments made for him.

Finding: Mr E's care plan did not reflect his drug use or detail the aims/goals to address this.

Finding: Consultant 1 recommended to the court in June 2018 that a DRR be part of Mr E's sentence, with a view to addressing his use of illicit substances. This was not adopted by the court because the nature of Mr E's offence meant he did not meet the criteria for a DRR.

Finding: The Trust does not have a dual diagnosis service and is reliant on separate substance misuse services, though it is taking steps to embed dual diagnosis expertise in community teams.

Mental Health Treatment Requirement (MHTR)

4.109 An MHTR is "*intended for the sentencing of offenders of an offence(s) which is below the threshold for a custodial sentence and who have a mental health problem which does not require secure in-patient treatment*".[53] It is not court

[53] National Offender Management Service (2015) Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery.

ordered treatment (e.g., a CTO), but is treatment recommended by clinicians and endorsed by the court, that the service user agrees to undertake.

"*Before making an MHTR, the court must be satisfied that*:

1. *The mental condition of the offender requires treatment and may be helped by treatment, but does not warrant making a hospital or guardianship order (within the meaning of the Mental Health Act 1983).*

2. *Arrangements have been or can be made for the offender to receive treatment as specified in the order.*

3. *The offender agrees to undergo treatment for their mental health condition.*"[54]

4.110 The MHTR is a sentencing option for offenders who do not need secure inpatient treatment and can be treated in the community. Pre-sentence reports may be submitted to the court as part of the assessment process (e.g., by a mental health practitioner) and the offender is subject to a mental health assessment.

4.111 Implementation and delivery of an MHTR requires multi-agency working (e.g., between health and the probation service).

"*Enforcement of an MHTR by probation is concerned with breaching the conditions of the order but not the treatment itself. An MHTR is not court ordered treatment it is treatment entered into by an individual and endorsed by the court. Enforced mental health treatment may only be made under an appropriate selection of the Mental Health Act 1983 …*"[55]

4.112 Mr E was sentenced to a minimum of 10 months imprisonment, suspended for 18 months on 26 June 2018. He received a 40-day RAR and was subject to an MHTR, the conditions for which were:

- To attend regular outpatient appointments with a named consultant psychiatrist.

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https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

[54] National Offender Management Service (2015) Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

[55] National Offender Management Service (2015) Mental Health Treatment Requirements: Guidance on Supporting Integrated Delivery.
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/391162/Mental_Health_Treatment_Requirement_-_A_Guide_to_Integrated_Delivery.pdf

- To be seen as required by a community psychiatric nurse (CPN)/social worker.

- To remain compliant with prescribed medication.

- To engage in therapeutic activities as required by psychiatrist/CPN/social worker.

4.113 The MHTR reflected most, but not all of Consultant 1's recommendations submitted to the court earlier in the month.[56] They did not include the condition that that Mr E be required to engage with drug and alcohol services. We discussed Mr E's drug use in 'Mr E's drug use' (paragraphs 4.97 to 4.106).

4.114 The conditions of the MHTR are not immediately obvious in Mr E's clinical notes. The Trust internal report noted that it is currently not Trust practice to request details of completed legal orders because there is no Trust policy or procedure in place to support this. The internal report makes a recommendation[57] in relation to this point which we support. We discuss this further in 'Progress with internal action plan' (paragraphs 5.26 to 5.30).

4.115 We have previously detailed engagement between Trust services and the probation service in 'External – probation' (paragraphs 4.88 to 4.96). There is no evidence probation and Trust services held an introductory meeting following Mr E receiving an MHTR. There is evidence the two agencies were in contact (e.g., by phone), but nothing was formalised (e.g., regular meetings). Consultant 1 told us they were not contacted directly by the probation service when Mr E received an MHTR to discuss the conditions and/or agree a communication strategy. However, Probation Officer 1 did later write a letter to introduce themselves as Mr E's offender manager which Consultant 1 found helpful. We were told the CMHT would usually receive details of court proceedings from the CJLDT. The probation service confirmed the CJLDT would be responsible for communicating details of the MHTR.

4.116 Consultant 1 sent Probation Officer 1 a summary of the CPA review on 11 December 2018. Consultant 1 explained that Mr E had requested that full details not be shared. Probation Officer 1 replied on 19 December 2018 advising that the conditions of Mr E's MHTR meant they needed full details of his CPA reviews and they must be kept fully informed about his mental health. The letter further detailed difficulties trying to engage with Mr E, for example in relation to his accommodation and substance misuse.

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[56] Consultant 1's recommendations sent to the court on 6 June were for Mr E: "*1) To attend regular outpatient appoints with the named consultant psychiatrist, 2) To be seen as required by CPN/social worker, 3) To remain compliant with prescribed medication, 4) To engage in therapeutic activities, 5) To engage with drug and alcohol services*".

[57] "*Trust to develop a process to ensure that MHTR documentation is shared with the CMHT*".

4.117 We spoke to Consultant 1 and Care Coordinator 1 about their contact with the probation service about the MHTR. They described it as sporadic, though noted the probation service was also experiencing difficulties engaging Mr E. We were told the CMHT took steps to include Probation Officer 1 in their CPA meetings with him, but they were unavailable for the first meeting and were not informed of a change in location for the second meeting, and therefore missed it. As a result, CMHT staff did not formally[58] meet Probation Officer 1 prior to the incident in January 2019. Consultant 1 and Care Coordinator 1 were clear that their understanding was that probation was the lead agency in relation to managing Mr E's MHTR, although they were responsible for ensuring Probation Officer 1 was informed when Mr E missed appointments.

4.118 The probation service confirmed there was not a formal information sharing process in place at the time of the incident. However, they advised there was regular information sharing between Probation Officer 1 and Care Coordinator 1, by phone and email, in relation to contact with Mr E and if he had missed appointments. This does not reflect Care Coordinator 1 or Consultant 1's recorded description of contact. The health notes do not reflect regular liaison between the two agencies.

4.119 Trust and probation services were responsible for managing Mr E's adherence to the MHTR. It would have been good practice for the two services to have met shortly after Mr E received his MHTR, to ensure everyone was clear as to the conditions of the MHTR and to agree information sharing between the two agencies. It would have been helpful for the two agencies to have clarified what would be considered a breach of the MHTR, and what steps should be taken in response to Mr E not adhering to the conditions of the MHTR. There is no evidence Consultant 1 was aware that sending an abridged version of the December CPA meeting to Probation Officer 1, in accordance with Mr E's wishes, was not in adherence to the information sharing requirements of the MHTR that the probation service be kept informed about Mr E's mental health.

4.120 There is evidence Mr E was not adhering to the MHTR. Equally he had been remanded in custody in July/August 2018 following his arrest for possession of an offensive weapon whilst subject to a suspended sentence.

4.121 We set out below a summary of Mr E's MHTR and his non-compliance with the conditions.

Table 3: Mr E's non-compliance with MHTR conditions

MHTR condition	Details of Mr E's non-compliance

[58] Care Coordinator 1 met Probation Officer 1 in passing on 29 August 2018 when attending Mr E's hostel to give him his medication.

To attend regular outpatient appointments with named consultant psychiatrist.	Mr E missed his CPA review on 3 December 2018.
To be seen as required by CPN/social worker.	Mr E engaged inconsistently with Care Coordinator 1. He often did not answer his phone, sometimes curtailed meetings, or would refuse to see Care Coordinator 1 when they visited the hostel (e.g., 21 September 2018).
To remain compliant with medication.	It was known that historically (e.g., reported at a June 2017 MAPPA meeting) Mr E did not take his prescribed medication consistently, and would often take half the prescribed dose. The forensic assessment report in August 2018 advised taking a serum olanzapine level might be helpful to clarify how much of his medication Mr E was taking (the clinician noted Mr E was "*unusually thin for someone on 20mg olanzapine*"). The Trust internal report details that the team intended to review this during the 3 December CPA review, but Mr E did not attend (there is no evidence it was attempted at the 10 December CPA review).
To engage in therapeutic activities as required by psychiatrist/CPN/social worker.	There is no evidence any form of therapeutic activity had been agreed between Mr E and the mental health team, rather the team was focussing on the practicalities of Mr E's life e.g., accommodation.

4.122 Consultant Forensic Psychiatrist 2's forensic assessment in August 2018 noted the MHTR[59] did not: "*… add the additional layers of formality and compulsion to the delivery of his care in a community setting*".

4.123 Mr E attended court in October 2018 for sentencing[60] where he was given a conditional discharge to run in parallel with his suspended sentence and the MHTR. There is no evidence in the notes of liaison between the probation service and the CMHT in preparation of Mr E's attendance to court, and for whether the conditions of his MHTR should be reviewed. Mr E's court

[59] Consultant Forensic Psychiatrist 2 also referred to a DRR, however, Mr E was subject to a RAR not to a DRR.

[60] On 24 August 2018 Mr E had been granted unconditional bail and court adjourned sentencing until 12 October 2018.

appearance should have acted as a prompt for probation and Trust services to have reviewed Mr E's compliance with the conditions of his MHTR, and their roles in managing and/or supporting this. It is our view that the court should have been informed that Mr E was not adhering to the conditions of his MHTR.

4.124 Probation Officer 1's letter in December 2018 indicated concerns about Mr E's engagement with the service and adherence to the MHTR. This should have served as a prompt for the two services to meet with a view to addressing Mr E's lack of compliance, and to consider what options were available to the team in terms of encouraging his compliance and/or the agencies undertaking further action in relation to this. The probation service told us that non-compliance with the conditions of an MHTR alone would not have instigated a return to court. However, it remains our view that Mr E's lack of compliance with the conditions of the MHTR should have prompted a dialogue between the two agencies. There is no evidence this was considered by either agency prior to the incident in January 2019 (however, we note the probation service had separately issued a final warning to Mr E in relation to a missed appointment and ongoing concerns about his engagement with them).

Finding: There is no evidence the CMHT and the probation service agreed an approach to monitor or communicate about Mr E's adherence to the conditions of the MHTR. There is no evidence they agreed what steps the CMHT should take in the event of Mr E failing to adhere to the conditions of the MHTR.

Finding: There was a missed opportunity for the probation service and CMHT to work together to review Mr E's adherence to the conditions of his MHTR in preparation for his attendance at court for sentencing in October 2018.

Finding: Mr E did not adhere to the conditions of his MHTR. There is no evidence the CMHT escalated this to the probation service.

Family engagement

Care and treatment

4.125 There is guidance available about the role of families and carers in service user's care. NICE guidance *Service User Experience in Adult Mental Health* (2011) advises:

"*Discuss with the person using mental health services if and how they want their family or carers to be involved in their care. Such discussions should take place at intervals to take account of any changes in circumstances, and should not happen only once … if the person using mental health services wants their family or carers to be involved, encourage this involvement and:*

- *Negotiate between the service user and their family or carers about confidentiality and sharing of information on an ongoing basis.*

- *Explain how families or carers can help support the service user and help with treatment plans.*

- *Ensure that no services are withdrawn because of the family's or carers' involvement, unless this has been clearly agreed with the service user and their family or carers.*"[61]

4.126 NICE guidance *Psychosis and Schizophrenia in Adults* (2014) recommends:

"*Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user … this can be started either during the acute phase or later, including inpatient settings*"[62]

4.127 The Trust CPA guidance (2016) says reviews should take into account the views of carers and involve them in care planning, where appropriate. Family members can be considered carers, but the policy does not provide direction on the involvement of family members not considered to be a carer. We discuss in 'Support to Ms A' (paragraphs 4.133 to 4.147) that we consider Ms A to have met the Trust criteria for being a carer and that she should have been involved in Mr E's CPA reviews.

4.128 CMHT staff were in regular contact with Ms A, particularly during 2017, about Mr E and it was documented in the notes and clinic letters that Mr E often sought support from his mother and siblings when he felt unwell, though they had a difficult relationship due to his variable behaviour.

4.129 There is evidence that the CMHT staff were receptive to Ms A's contact and acted on her concerns in relation to Mr E's wellbeing, for example, arranging an urgent CPA review and arranging an informal admission in February 2018 after she told them he was unwell and had indicated he would consider an admission to hospital. Equally, there were times when the CMHT sought her input. Of note, Consultant 1 spoke with Ms A in April 2017 after a MAPPA meeting to obtain further detail about Mr E; this information was subsequently shared at the next MAPPA meeting and reflected in Mr E's progress notes.

4.130 There is no evidence Ms A was invited to contribute to, or attend, Mr E's CPA reviews, or that this was ever discussed with either of them. However, we note the documented CPA reviews do reflect Ms A's views about Mr E's mental health (i.e., the team was taking them into consideration). As noted above, Trust policy does not reference the involvement of families, only carers

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[61] NICE clinical guidance [CG136]: https://www.nice.org.uk/guidance/cg136/chapter/1-Guidance

[62] NICE clinical guidance [CG178]: https://www.nice.org.uk/guidance/cg178/resources/psychosis-and-schizophrenia-in-adults-prevention-and-management-pdf-35109758952133

(which family members can be), in CPA reviews. Consequently, the team was acting in line with Trust policy by not inviting Ms A to contribute to or attend the reviews, given there is no evidence she was considered to be Mr E's 'carer'; however, it would have been good practice to have agreed a formal process with Ms A for her input into CPA reviews.

4.131 Ms A told us she did not feel Trust staff fully appreciated the knowledge Mr E's family had about his mental health, his symptoms and behaviours. For example, she told us that during Mr E's mental health assessments in 2017, she did not think the assessing staff were ever fully aware of the extent of his illness or cognisant that he was proficient in masking his symptoms for short periods of time. Ms A told us she felt quite helpless in relation to these assessments. She and the family were monitoring Mr E's mental health daily, and were clear when he was deteriorating, but she did not think this was appreciated by the assessing staff. Ms A felt her family did not have enough input into Mr E's MHA assessments. Equally, she found it difficult when the assessing staff asked for her views in front of Mr E. She said this put her in a difficult position, particularly after they left, and she had to manage any aftermath about this with Mr E.

4.132 Ms A told us she was very clear with CMHT staff that Mr E might hurt himself or someone else. It is recorded in the April 2017 MAPPA meeting minutes that she was concerned he would kill someone. It was also documented in the MAPPA minutes that Mr E's family thought he remained untreated and unwell, but this is undated.[63] Ms A's concern that Mr E might kill someone was also noted by Consultant 1 as part of their reason for requesting Mr E be assessed under Section 3 MHA in April 2017.

4.133 Ms A described Consultant 1 as largely the exception to her views about Trust services which she felt placed too much emphasis on giving Mr E his medication. Ms A noted Consultant 1 had tried hard to have Mr E detained under the MHA and subject to a legal order as part of his sentencing in June 2018.

Finding: Ms A, Mr E's mother, was actively involved in his life and the CMHT regularly engaged with her in relation to his management and wellbeing. Ms A contacted the team when she was concerned about Mr E's wellbeing. There is evidence the team acted in response to her input. However, there is no evidence the CMHT agreed a formal approach with Ms A in relation to information sharing, and she was not invited attend Mr E's CPA reviews or contribute to his care plan. This was a missed opportunity to formally receive regular input from Ms A about Mr E's mental health and wellbeing.

[63] There was one set of minutes for the MAPPA meetings between April and September 2017 – new entries were identified by date.

Support for Ms A

4.134 The Trust's Carer's Policy (2015) describes carers as family, friends or neighbours who provide "*unpaid support for people with mental health problems … If someone is involved with and gives significant support to a Trust service user, irrespective of whether they live with that person or not, they should be considered a carer and be actively engaged by the care team.*"

4.135 The Trust policy says carers should be involved in care planning and offered support, including the option of an assessment of their own needs and care plan. In accordance with the Care Act (2014), it is the local authority who is responsible for undertaking needs assessments and developing care plans, but there is an expectation in Trust policy that Trust staff signpost carers as required.

4.136 Mr E sometimes lived with Ms A, and she regularly provided support of his daily living e.g. laundry and meals (she provided him with food when he lived in a hostel in 2018). Ms A was in regular contact with the CMHT about Mr E's mental health and was someone they contacted when trying to locate him.

4.137 Ms A told us she did not feel mental health services took her concerns about Mr E seriously and that the family were left to manage Mr E without support. CMHT staff advised her that in the event of an emergency she should take Mr E to the local A&E, but she told us she would not have been able to facilitate this if Mr E was unwilling to go.

4.138 It is our view that Ms A met the Trust's criteria of a carer, particularly in 2017. However, there is no evidence in the notes that the CMHT discussed a carer's assessment with Ms A or asked her if she needed support.

Finding: There is no evidence the CMHT formally considered Ms A to be Mr E's carer or offered her support in the context of being his carer. Ms A met the Trust's criteria for a carer and should have been signposted by the CMHT to the local authority carer's assessment.

Family questions submitted to this independent investigation

4.139 We met Ms A at the outset of the investigation. She provided feedback about the terms of reference and submitted three questions she wanted the investigation to address. We have been able to address two of Ms A's questions, the third was outside the scope of this investigation (arrangements were made for Ms A to liaise with the Trust about this). Ms A's questions are presented in italics.

Mr E was seen by the CMHT many times during the two years prior to the incident, but how many appointments could be considered meaningful, as opposed to simply giving Mr E his medication?

4.140 We agree that Mr E was seen many times by the CMHT over the two-year period and the depth of this contact varied. The table below provides a summary of the CMHT's contact with Mr E between 2017 and 2018.

Table 4: CMHT contact/attempted contact with Mr E in 2017 and 2018.[64]

Mapped Event	2017	2018
Failed contact with Mr E (e.g., phone calls not answered)	19	21
Phone call with Mr E	24	21
Home visit/appointment missed	10	5
Home/hostel visit	1[65]	7
CPA review	3	7
Missed CPA review	3	2

4.141 The CMHT was often in contact with Mr E, but it is unlikely they would describe all contact as 'meaningful'. By the CMHT's own admission, they found it difficult to engage with Mr E who would sometimes miss appointments or attend at the wrong time. At times he appeared reluctant to speak on the phone and/or would not answer his phone at agreed rescheduled times. Mr E sometimes lost his phone and changed his address several times, which created further difficulties, particularly for Care Coordinator 1, when trying to make contact. The notes indicate Care Coordinator 1 would liaise with Ms A and Mr E's partner in attempts to locate Mr E. Care Coordinator 1 would also send Mr E reminders for appointments (e.g., text messages) and ask hostel staff to remind Mr E of upcoming appointments. Consultant 1 was complimentary of Care Coordinator 1's efforts to engage Mr E, describing them as an "*assertive outreach*" type of approach that went beyond the remit of the CMHT.

4.142 Care Coordinator 1 told us it was difficult to engage with Mr E, both in terms of locating him, and during actual contact. Mr E could be reluctant to engage during meetings, sometimes providing limited answers or ending meetings without warning. Some meetings were brief and centred on giving Mr E his medication. Care Coordinator 1 said contact with Mr E was largely reliant on his willingness to engage; he was not under a legal framework and as such,

[64] The CMHT had no contact with Mr E in 2019 prior to the incident.

[65] The CMHT decided in March 2017 that they would not visit Mr E at home in view of his risks and concerns that he sometimes concealed weapons.

there was no recourse to compel Mr E's engagement (the exception to this was the MHTR).

4.143 We note the probation service told the CMHT that they were experiencing difficulties getting Mr E to engage both in meetings and their plans for him in relation to the MHTR. Probation Officer 1 described Mr E's engagement as "*minimal*" in their letter to Consultant 1 in December 2018.

4.144 During 2017 and 2018, the CMHT had 24 and 21 phone calls, respectively, with Mr E. We cannot comment as to the detail of these calls and/or if they would be considered meaningful. Equally, the notes indicate not all visits to see Mr E at his hostel were meaningful and often involved, as Ms A observed, simply giving Mr E his medication.

4.145 However, Consultant 1 and Care Coordinator 1 held three CPA reviews with Mr E in 2017 and seven with him in 2018 (Trust policy mandates one CPA review a year with others as required). The notes from these meetings reflect discussion about a variety of issues and agreed next steps, for the team and Mr E. We consider these reviews with Mr E to be meaningful appointments. Mr E's last CPA review took place on 10 December 2018.

What was Mr E's diagnosis; when did dual diagnosis start being considered?

4.146 Mr E's diagnosis was paranoid schizophrenia with multiple substance misuse. Consultant 1 told us they considered his diagnosis extended to dissocial personality traits, but they did not document this in the notes.

4.147 There is evidence the CMHT was aware in early 2017 of Mr E's substance misuse and how this impacted his mental health. Mr E was noted by CMHT staff to become more paranoid when using illicit substances.

4.148 The first entry in the notes in relation to dual diagnosis is in March 2017 but in the context of cluster[66] 16 (e.g., cluster dated 20 March 2017 in clinic letter of 22 March 2017). Dual diagnosis was not listed as part of Mr E's diagnosis in Consultant 1's last clinic letter to Mr E's GP dated 11 December 2018.

[66] Cluster: *"… a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MCHT). The clusters allow for a degree of variation in the combination and severity of rated needs".* NHS England (2016/17) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499475/Annex_B4_Mental_health_clustering_booklet.pdf

5 Trust's internal investigation and action plan

5.1 The NHS England SIF (2015) does not give an explicit definition of a serious incident (SI), rather, it says the classification should be judgement based. It gives examples which include:

"[a] *homicide by a person in receipt of mental health care within the recent past*"

5.2 There are seven principles to SI management which include being open and transparent, objective, proportionate, timely and responsive. The SIF says:

"*Investigations of serious incidents are undertaken to ensure that weaknesses in a system and/or process are identified and analysed to understand what went wrong, how it went wrong and what can be done to prevent similar incidents occurring again*".

5.3 The framework says a systems-based methodology – typically known as root cause analysis (RCA) – should be adopted to identify:

1. "*The problems (the what?);*
2. *The contributory factors that led to the problems (the how?) taking into account the environmental and human factors and*
3. *The fundamental issues/root causes (the why?) that need to be addressed*".

5.4 The SIF says that when more than one organisation has been involved in a service user's care, all parties, where possible, should take steps to undertake a single investigation.

5.5 The Trust's Reporting, Management and Review of Adverse Incidents Policy (2017) sets out the steps for reporting and managing serious incidents. It details the role of individuals, groups and committees and extends to the assurance process for reports. The policy sets out the criteria for level 1 and level 2 investigations.

5.6 The policy details the RCA process to be applied to investigations, sets out the roles of the lead investigator, assistant investigator, the panel, and the process for report writing and factual accuracy checking.

Internal investigation

5.7 The Trust's internal investigation began in January 2019, the final report is dated August 2019. The investigation was led by two reviewers and supported by a panel of five staff. The report used an RCA methodology, supplemented by a fishbone diagram and tabular timeline. The investigation identified four CDPs and 10 SDPs. The report did not identify a root cause (as can often be

the case) but did identify 15 contributory factors, subdivided according to factor (e.g., patient, individual staff, and task factors). The investigation made 12 recommendations.

Analysis of the Trust's internal investigation

5.8 We have developed a framework of 25 standards for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency (NPSA),[67] the NHS England SIF[68] and the National Quality Board (NQB) Guidance on Learning from Deaths.[69] We also reviewed the Trust's policy for completing SI investigations to understand the local guidance to which investigators would refer.

5.9 The 25 standards for assessing the quality of SI reports are based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice.

5.10 Details of our assessment of the internal investigation using these standards can be seen in Appendix C. Our findings are summarised in the table below:

Table 5: Summary assessment of the Trust's internal investigation

Rating	Description	Number
(green)	**Standards met**	20
(amber)	**Standards partially met**	5
(red)	**Standards not met**	0

5.11 In our view, the Trust undertook a comprehensive investigation of Mr E's care and treatment. We provide further detail of this assessment below, using our three themes of credibility, thoroughness and impact.

Credibility

5.12 The level 2 investigation was undertaken by an appropriately experienced team using a panel approach. The terms of reference were broad and tailored to address elements of Mr E's care (e.g., drug use).

5.13 We note the investigation was not completed in 60 days, but consider the requests submitted by the investigation team to the CCG for extension to be reasonable. Equally, there was an ongoing dialogue between the Trust and

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

[68] NHS England (2015) Serious Incident Framework: Supporting Learning to Prevent Recurrence. https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

[69] National Quality Board (2017) National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

CCG in relation to the report sign off which took time. Separately, we note the investigators had to wait several weeks to receive information from the probation service.

Thoroughness

5.14 The Trust undertook a robust investigation, underpinned by an RCA methodology and reference to Trust policy and expected practice.

5.15 The report explores a number of areas including inter-agency communication, MAPPA, recommendations from the forensic assessment (August 2018) and broader quality assurance.

5.16 We agree with the SDPs and CDPs identified, though note some overlap and in one instance consider the SDP to be a CDP (please refer to Appendix C for more information). We agree with the contributory factors identified.

5.17 However, we note that Ms A told us there are errors in the tabular chronology and that we too have identified a small number of errors e.g., the date of a MAPPA meeting is incorrect. The Trust investigators told us Ms A was provided with a separate Trust contact to support her through the investigation process, and their expectation was that any concerns about the accuracy of the report would have been fed back via that individual. They did not receive feedback. However, our sense from Ms A was that she did not feel she had an opportunity to provide further comment about the Trust report.

5.18 We note the final report we have been provided with contains sections highlighted in red. We were advised by the CCG that this is illustrative of their quality assurance process with the Trust (i.e., tracking changes) but their expectation was a final version should be available without highlighted additions.

Impact

5.19 It is our view that the investigation provides a comprehensive account of what happened and, on balance, why it happened. However, as is inevitably the case when scrutinising another review, there are elements of Mr E’s care that could have been explored further by the investigation. In particular, we note Consultant 1 contacted forensic services on a number of occasions in relation to Mr E’s risk and management, but their input largely hinged on Mr E being admitted. The internal investigation makes no comment about what should have happened when Mr E was not admitted, for example, highlighting the lack of community-based assessment options.

5.20 Equally, the report highlights omissions in relation to processing a MAPPA referral (the authors indicated some doubts about whether the referral would be accepted) but makes less comment about the CMHT’s role in

implementing the MHTR. Mr E was not adhering to the conditions of the MHTR, but the investigation makes limited comment about the CMHT's engagement with the probation service or the recourse available to the team when Mr E was not complying with the MHTR conditions. Whilst the MAPPA referral should have been processed promptly, Mr E was subject to an MHTR at that time, and this was something the CMHT, working with the probation service, could have sought to use to engage him in treatment and/or seek further support from the court (through the probation service).

5.21 The internal investigation recommendations, if implemented would likely lead to changes in practice, though it is our view that the recommendations do not fully address the concerns identified. For example, there is a recommendation in relation to agreeing a process to ensure the CMHT receive MHTR paperwork from the probation service, but there is no recommendation in relation to improving broader working practices between the two agencies (e.g., joined-up working).

Finding: The Trust's internal investigation is detailed and comprehensive. It utilises RCA methodology which is underpinned by Trust policy and expected practice. The findings are balanced and the associated recommendations appropriate. We identified areas in which further enquiries could have been undertaken, and whilst steps were taken to engage Ms A in the investigative process, there is no evidence she was given an opportunity to provide comment about the final draft report.

Communication with Mr E's family during and after the internal investigation

5.22 The internal investigation lead investigators informed us the Trust provided Ms A with a separate contact to act as her liaison during the investigation.

5.23 The lead investigators met with Ms A in March 2019 to discuss their investigation and identify any questions she had. One of the lead investigators and Ms A's Trust liaison met with her at the end of the investigation to share the report findings. However, as previously noted, there is no evidence Ms A was given an opportunity to provide feedback in relation to the report (she identified errors in the chronology). The lead investigators were clear with us their expectation was that Ms A would have submitted any feedback via her Trust liaison, who was her primary point of contact, but there is no evidence of further engagement by Trust staff with Ms A in relation to this.

Communication with Mr C's family during and after the internal investigation

5.24 The Trust internal report makes no reference to Mr C's family. The lead investigators told us the police asked them not to contact the family whilst criminal proceedings were ongoing. They followed up with the police at a later date and were again asked not to make contact.

5.25 Mr C's family confirmed they had not been contacted by the Trust about its internal investigation and did not receive a copy of the final report. In their feedback to us about our draft report, Mr C's family noted legal proceedings against Mr E finished in June 2019, but the Trust did not contact them after this time to share the internal investigation report.

Progress with internal investigation action plan

5.26 This section contains the findings arising from the assurance review of the action plan. Our assessment is meant to be useful and evaluative. We use a numerical grading system to support the representation of 'progress data', which is intended to help organisations focus on the steps they need to take to move between the stages of completed, embedded, impactful and sustained. These are as follows:

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

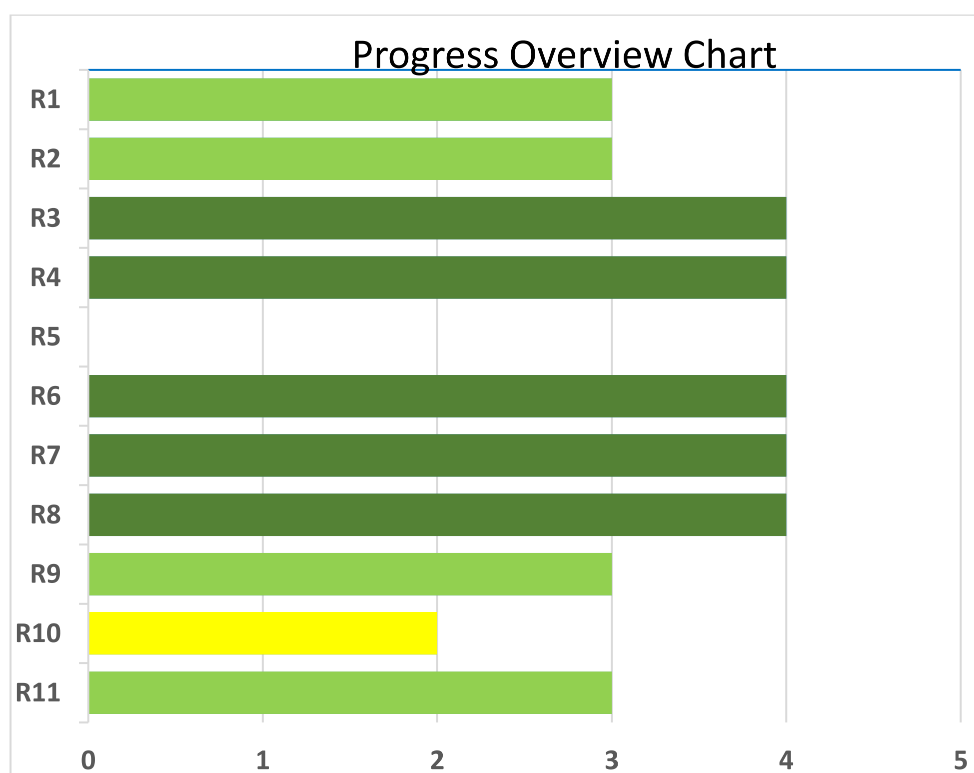
5.27 The Trust's internal investigation made 12 recommendations, but two[70] of these were merged as part of the Trust action plan. Consequently, we report on the Trust's progress with the 11 recommendations, which were:

1. Community lead for quality and standardised practices to be identified.
2. Implementation of Management and Supervision Tool (MaST) caseload management.
3. Better identification and shared team understanding and management of the 'critical few' patients with a CMHT.
4. "*My supervision*" tool to be actively used during supervision.
5. Consider the development of a multi-agency hub to receive complex high-risk referrals for advice, support or action.
6. Trust-wide training and implementation of risk formulation.
7. "*Risk to others*" training for CMHT staff.

[70] "*Consider the development of a multi-agency hub to receive complex high-risk referrals for advice, support or action*" (recommendation 10 in the Trust's internal investigation report) and "*Trust to develop a process to ensure that MHTR documentation is shared with the CMHT*" (recommendation 11 in the Trust's internal investigation report).

8. To develop specialised training in risk formulation for professional clinical staff.
9. The Trust to develop a risk assessment and management training module to form part of organisational induction and an annual mandatory refresher.
10. Care plans and risk assessments to be viewed as dynamic and live documents.
11. To develop a quality assurance framework to audit CPA care plans and risk assessment documents.

5.28 The chart below presents a summary of the Trust's progress against the action plan. Further detail of our assessment can be seen in Appendix D.



5.29 The Trust has made significant progress in implementing its action plan, particularly in relation to developing its effective risk intervention skills (eRISK) training program. However, we identified areas in which further evidence of assurance is required, for example in relation to recommendation 10.

5.30 We received no documentary evidence in relation to recommendation 5 (the combined recommendation). We have no reason to doubt the Trust's reporting of its progress with its action plan (all actions were reported as complete in October 2021), but we have not received the underpinning evidence.

Finding: The Trust has made significant progress in implementing its action plan, but further evidence is required to provide assurance that the action plan has been completed.

6 Conclusions and recommendations

6.1 Mr E had a diagnosis of paranoid schizophrenia with multiple substance misuse. He had a chaotic lifestyle, characterised by extensive drug use, unstable living arrangements and at times, threatening behaviour. Mr E's engagement with the CMHT was voluntary. With the exception of an MHTR, he was not subject to any legal frameworks and the team had no recourse to mandate his engagement in care and treatment.

6.2 It is our view that the CMHT had a comprehensive understanding of Mr E's risks and a clear long-term treatment plan, but this was reliant on Mr E being subject to an inpatient admission. The CMHT was trying to engage and work with Mr E although, like the Trust's internal investigation, we identified gaps in record keeping. For example, risk and care planning documentation was not completed in line with Trust policy. However, we do not consider this to be representative of the team's understanding of Mr E, their attempts to engage him in treatment, or to manage his risks. Consultant 1's clinic letters and correspondence with other agencies demonstrated a comprehensive understanding of Mr E's risks and her intended long-term treatment plan for him. Similarly, the notes indicate an assertive approach on the part of Care Coordinator 1 in terms of trying to support Mr E and liaising with other agencies.

6.3 However, the proposed treatment plan for Mr E was reliant on a sustained period of assessment and treatment in an inpatient setting; something which Mr E was unwilling to consider. There were occasions in 2017 when the team considered Mr E could be detained under the MHA and arranged assessments, but on both occasions staff concluded he was not detainable under the MHA.

6.4 Mr E's mother, Ms A, was clear with CMHT staff that he was a risk to himself and to others, and she was frustrated by the lack of treatment given to him. She was mindful he could mask his symptoms and the notes suggest she felt staff failed to appreciate the significance or respond effectively to this. It is of note that one of her questions to this independent investigation was how many of the CMHT's appointments with Mr E could be considered meaningful, as opposed to simply giving Mr E his medication.

6.5 To a certain extent, the CMHT echoed this frustration. The CMHT was limited in what care and treatment it could offer Mr E given their reliance on his willingness to engage with them. We note:

- The CMHT arranged MHA assessments with a view to Mr E receiving inpatient treatment, but he was not deemed to be detainable.
- The CMHT requested input from forensic services, but this was dependent on Mr E being admitted to the ward.

- When Mr E was admitted to the ward as an informal patient, the ward team, despite Consultant 1's prompting, did not implement the CMHT inpatient care plan prior to Mr E discharging himself against medical advice.

- Consultant 1 asked that the court include a DRR as part of Mr E's sentence in June 2018, but he received a RAR due to his offence not meeting the criteria for a DRR.

- Mr E was not subject to any legal frameworks (e.g., a CTO) and his engagement with treatment was voluntary until he received an MHTR as part of his sentence in June 2018.

6.6 The MHTR was a voluntary arrangement and could not compel Mr E's engagement with services, but it provided the probation service and CMHT with a legal framework in which to respond to his disengagement. It is our view that the Trust and probation service should have been proactive in agreeing an approach to monitor and report on Mr E's adherence to the MHTR conditions, with the probation service escalating as required.

6.7 Had the homicide not occurred, the Trust and probation service should have been in discussions about Mr E breaching the conditions of the MHTR (separately Mr E was subject to a probation service final warning in relation to a missed appointment and concerns about his engagement with them). At the time of the homicide, nearly six months after Mr E received the MHTR, there was no evidence of formalised communication between the Trust and the probation service and limited steps being taken to address this.

6.8 The CMHT was largely left to manage Mr E alone, with limited support or input from other Trust services and/or external agencies.

Recommendations

Recommendation 1: The Trust and the probation service should agree a protocol for the management of MHTRs. This should include an information sharing agreement, key milestones for contact/meetings and escalation pathways when concerns are identified.

Recommendation 2: The Trust should review the provision of forensic services input to community services to ensure community teams have access to forensic assessments for CMHT-based high-risk service users.

Recommendation 3: The Trust should ensure that its process for involving affected families in its internal investigation process includes providing an opportunity for families to submit feedback on the draft report.

Recommendation 4: The Trust should review its CPA policy to ensure it reflects best practice guidance in relation to the involvement of the families of service users, beyond those formally considered 'carers', in CPA and care planning.

Recommendation 5: The Trust must ensure a service user's plan of care remains continuous if admitted to an inpatient ward from the community, with appropriate liaison and engagement with the community team and other services as required.

Recommendation 6: The CCG/ICB should ensure the Trust has addressed the outstanding elements of its internal investigation action plan within six months of receipt of this report.

Good practice

6.9 The Trust's internal investigation identified the "*strong leadership and tenacious approach*" of Consultant 1. We agree with this assessment. Consultant 1 worked hard to support Mr E, undertaking regular CPA reviews with him, liaising with Trust services and other agencies in relation to his care and treatment and his broader needs. Ms A spoke highly of Consultant 1 in relation to their attempts to help Mr E.

6.10 It is our view that Care Coordinator 1 also worked hard to engage Mr E in his care and treatment, trying different approaches, offering to meet him at different locations, and regularly reminding him of upcoming appointments. Care Coordinator 1 responded to concerns raised by Ms A and other agencies, attempting to contact Mr E and/or bringing forward meetings with Consultant 1. We note that records maintained by Care Coordinator 1 about Mr E did not wholly reflect these efforts. This was also identified by the Trust's internal investigation and there were resultant recommendations for the CMHT, but this does not detract from the assertive approach adopted by Care Coordinator 1 to engage Mr E in his care and treatment.

Appendix A: Terms of reference

Terms of reference for independent investigations under NHS England's SIF (2015) (Appendix 1)

The terms of reference for the independent investigation of (two unrelated cases), 2018/21219 and 2019/372, and an assurance review of the recommendations and action plans, are set by NHS England and NHS Improvement with input from NHS Liverpool CCG.

These terms of reference will be developed further in collaboration with the offeror and family members. However, the following terms of reference will apply:

Scope of the review

The Independent Investigating team will review the internal investigations and undertake a desktop review of both cases to consider the mental health care and treatment provided to the two service users whilst under the care of Mersey Care NHS Foundation Trust. The Independent Investigators will:

- Ensure that the service user and the affected families are informed of the review of 2018/21219 and 2019/372, and the review process. The investigating team will offer the families the opportunity to contribute, including development of the terms of reference.
- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's contact with services two years preceding the incident.
- Compile a comprehensive chronology of events leading up to the homicide.
- 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.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service users care plan including the involvement of the service user and the family.

- Review and assess compliance with local policies, national guidance and relevant statutory obligations.

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

Output

- Provide NHS England and NHS Improvement with a monthly update, detailing actions taken, actions planned, family contact and any barriers to progressing the investigation.

- Provide two separate written desktop reviews of the care provided to both service users.

- Provide a thematic analysis of the common pattern and themes from both cases.[71]

- Undertake an assurance follow-up review, 6 – 12 months after the report has been published, in conjunction with the CCG and Trust to assure that the report's recommendations have been fully implemented. Produce a report that may be made public.

Publication

- Following an independent legal review, the final report will be submitted to the NHS England and NHS Improvement Independent Investigations Review Group for acceptance and to discuss and agree the publication options. The affected families will be informed of the option agreed.

[71] It was initially believed that there were correlations between the two cases. However, once the investigation had started it became apparent that this was not the case. Therefore, this report has considered only the investigation into Mr E's care and treatment.

Appendix B: Documents reviewed

Mersey Care NHS Foundation Trust

- Policies and procedures
- Progress notes
- Care plans
- Risk assessments
- AMHP reports
- Meeting notes
- Referrals
- Police reports
- Criminal Justice Liaison MAPPA form, 26 April 2017
- MAPPA meeting minutes 13 September 2017
- Internal and external correspondence (e.g., Trust, CJLDT, HMP and GP)
- HMP health records
- MHCT Part 1 & Part 2 forms
- Clinic and appointment letters
- Forensic assessment report, dated 20 August 2018
- Correspondence with Mr E's family
- 72-hour report
- Internal investigation
- Action plan
    - Community Excellence year update
    - Community Excellence Network strategy group minutes, 22 October 2021
    - Community Excellence blog
    - Community Excellent summary report

- Community Excellence update
- Local Division Programme of change Steering Group agenda, 22 June 2022
- Example CPA report
- eRISK implementation plan and core team guide
- eRISK learning handbook
- example supervision report
- Safety Huddle example
- End Project Report, Management and Supervision Tool (MaST), February 2020
- Example agenda for community managers
- Local Service Division governance report, July 2022
- Updated CPA policy
- Terms of reference for Clinical Transformation Group
- eRISK training uptake report (May-July 2022)
- CPA mandatory training programme
- CPA report, May 2022

Liverpool CCG

- Trust's internal investigation documents and action plan
- SI panel meeting notes and feedback
- CCG chronology of the Trust's internal investigation review
- Policies
- Correspondence

Mr E's GP practice

- Mr E's GP records

The probation service

- Feedback form

- Information sharing guidance
- Serious Further Offence Review action plan

Appendix C: Analysis of the Trust's internal investigation

Rating	Description	Number
Green	Standards met	20
Amber	Standards partially met	5
Red	Standards not met	0

Standard		Niche commentary	Rating
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident.	Level 2 investigation.	Green
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	Broad terms of reference covering the service user's care and treatment. Reference made to use of illicit substances, alcohol and violent behaviour indicating the terms of reference have been tailored to the case.	Green
1.3	The person leading the investigation has skills and training in investigations.	Investigation panel with two lead reviewers: consultant forensic psychiatrist and mortality and incident practitioner. The report does not detail their investigative experience, but the nature of the roles is indicative of appropriate skill.	Green
1.4	Investigations are completed within 60 working days.	The investigation was not completed in 60 days, but we consider the reasons for this to be reasonable. It is unclear exactly when the investigation began, but we understand it was in January 2019 (the incident was reported on 7 January 2019 and approved for further investigation on 14 January 2019). The investigators requested extensions in March, April and June 2019. There is an audit trial of liaison with the CCG in relation to these requests (e.g., to accommodate Ms A's diary for interview and to obtain information from the probation service). The CCG asked that the final, approved report be submitted for their review by 4 July 2019. The report was discussed at the CCG Clinical Safety and Serious Incident Panel on 24 July 2019. There is evidence the report was subject to revision and further review following this meeting and was completed on 6 August 2019. The internal investigators told us that the Trust quality assurance process for the report was lengthy and contributed to the delay in	Amber

Standard		Niche commentary
		completing the report (e.g., the report goes through validation and is also submitted to the Governance Board and Trust Board in advance of submission to the CCG). Equally they advised there was a lengthy dialogue with the CCG about the report.
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report is written clearly in plain English.
1.6	Staff have been supported following the incident.	The report details support offered to staff in the context of contributing to the investigation, and in more general terms (e.g., occupational health and the staff support service).
Theme 2: Thoroughness		
2.1	A summary of the incident is included that details the outcome and severity of the incident.	The report contains a summary and outcome of the incident in January 2019. We note some parts of the executive summary are written in red print without explanation (it is our understanding this is reflective of the CCG review process and shows changes that have been made, but we would anticipate a final copy without red print).
2.2	The terms of reference for the investigation should be included.	The terms of reference are in the report.
2.3	The methodology for the investigation is described, that includes use of RCA tools, review of all appropriate documentation and interviews with all relevant people.	The report is described as an RCA investigation. A completed RCA fishbone diagram and a tabular chronology are provided in the report appendices.
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	Investigators met Ms A on 29 March 2019 to discuss the investigation and offer the opportunity to ask questions. Ms A told us, with hindsight, that this meeting took place too soon after the incident, when she was struggling to comprehend the series of events. Ms A felt it would have been helpful for this meeting to have been held at a later date, when she would have had an opportunity to review the timeline of events and information she held.

Standard		Niche commentary
		Mr C's family were not involved in the investigation. The internal investigators told us they were asked by the police to not make contact whilst criminal proceedings were underway. The report says the family did not respond to Trust contact.
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	Ms A was offered the opportunity to ask questions, the answers to which are detailed in a standalone section in the report. This is helpful for the reader. However, please note Ms A's feedback above (2.4) in relation to the timing of her involvement in the investigation. Ms A received a copy of the Trust report but told us she felt there were a number of errors, particularly in the chronology. For example, there is a reference to Mr E having an automatic weapon[72] which was reported to the police – it was Ms A who contacted the police and she advised he had a knife, not a gun. We identified an error in the chronology in relation to the date of the June 2017 MAPPA meeting (noted as occurring on 23 June, when the case notes indicate it took place on 27 June 2017). Ms A told us she was not invited to give feedback about the report to the Trust. We discussed this with the Trust lead investigators who told us their expectation was Ms A would have fed back any comments via her Trust contact (assigned as part of the duty of candour), but they received no feedback. There is no evidence Ms A was informed of this opportunity. Mr C's family were not involved in the investigation. The report says the family did not respond to Trust contact. The internal investigators did not know if the final report was shared with the family (they advised that this was separate to their role).
2.6	A summary of the patient's relevant history and the process of care should be included.	The report contains a summary of Mr E's history.

[72] Please note this incident predates our timeframe of review.

Standard		Niche commentary
2.7	A chronology or tabular timeline of the event is included.	The report contains a detailed tabular chronology.
2.8	The report describes how RCA tools have been used to arrive at the findings.	The appendices contain a tabular timeline and RCA fishbone diagram. The report does not specifically explain its application of these tools, but we consider these to be self-explanatory.
2.9	Care and service delivery problems are identified (including whether what were identified were actually CDPs or SDPs).	Four CDPs and 10 SDPs were identified. The CDPs are correctly identified, but we consider one SPD to be a CDP: SDP: *"The CPA care plan document does not adequately reflect or evidence the agreed treatment plan …"* The same SDP goes on to cite evidence that staff were engaging with Mr E; this is unnecessary when setting out CDPs and SDPs.
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	Contributory factors are identified and subdivided into: patient, individual, task, work conditions and environment, organisational and strategic factors, and education and training factors.
2.11	Root cause or root causes are described.	The report does not identify a root cause but provides reference to the contributory factors.
2.12	Lessons learned are described.	The report summarises that all staff need to recognise that risk and safeguarding is "*everyone's business*". It sets out four areas for action plan development. These are separate from the 12 recommendations identified.
2.13	There should be no obvious areas of incongruence.	The report tabular chronology contains a small number of errors and omissions. For example, the April 2017 MAPPA meeting is not included, and the wrong date is listed for the June 2017 MAPPA meeting. Ms A gave us examples where she felt the chronology was inaccurate. The report identifies an SDP in relation to the management and submission of the MAPPA referral in late 2018 but goes on to say it was unlikely Mr E would have been accepted onto the caseload. It also notes Mr E's probation officer advised in December 2018 that he would

Standard		Niche commentary
		not be eligible for MAPPA based on the nature of his offence.[73] It is our view, that whilst important, the report over emphasises the delayed MAPPA referral (which it said was unlikely to be accepted) at a time when Mr E was subject to an MHTR, the conditions of which he was breaching. The report notes Probation Officer 1's statement that a failure to share the full CPA record was in breach of the MHTR, but the report does not set out what was agreed between the Trust and the probation service in terms of monitoring and implementing the MHTR. Utilising the conditions of the MHTR was an option available to CMHT staff in December 2018 at a time when the MAPPA referral was yet to be fully actioned. Separately, the report comments on the forensic assessment in August 2018 (and resultant actions) but makes no comment as to the lack of assessment during 2017 despite Consultant 1 asking for input on several occasions. Forensic services advised they were willing to review Mr E once admitted, but there is no comment as to what forensic input was available when Mr E was not admitted (e.g., in the community). The report says there was no treatment plan during Mr E's informal admission in February 2018, but we identified a care plan dated 16 February 2018 which contains a treatment plan.
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The internal investigation met its terms of reference.
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues.	The terms of reference are appropriate in breadth and detail for the level of investigation. Specific reference is made to Mr E's use of illicit substance, alcohol, and his violent and assaultive behaviour.

[73] The internal report notes that as part of its engagement with probation during its investigation, they advised that a MAPPA referral was appropriate, in conflict with Probation Officer 1. However, we note Probation Officer 1 told the Trust investigation that her assessment was based on information available to her at the time (there is no evidence she was informed Mr E was making threats to other residents or stealing money).

Standard		Niche commentary	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	The report provides a detailed account of events. It details Trust policy and national guidance in terms of expected practice. The report does not always provide a complete explanation for events, but there is evidence it has explored what happened. For example, it is noted that Care Coordinator 1 was unable to explain the delay in submitting the MAPPA paperwork. It is our view that whilst the recommendations relate to the findings, there are elements of the CDPs and SDPs that have not been addressed which we consider would consequently mean the risk of reoccurrence has not been mitigated. There is no expectation that each CDP and SDP have a recommendation, but we consider there are instances where they were warranted. For example, there is an SDP in relation to the lack of in person meetings between probation and the CMHT, in terms of understanding agency roles and agreeing an escalation process. The report makes one recommendation in relation to the MHTR which is: "*Trust to develop a process to ensure that MHTR documentation is shared with the CMHT*". There are no recommendations specifically about developing working (and escalation) arrangements between the CMHT and probation in relation to MHTRs (we have made a recommendation in relation to this point). Equally there is no recommendation in relation to the CMHT goals not being implemented during Mr E's inpatient admission, although this in part may be due to the short time in which Mr E was on the ward before he discharged himself against medical advice. We have made a recommendation in relation to this point. There is also a recommendation in relation to supervision, though supervision is not identified as an SDP.	
3.3	Recommendations that relate to the findings and that lead to a change in practice are set out.	The recommendations relate to the investigation findings, and if implemented, would lead to changes in practice.	

Standard		Niche commentary
3.4	Recommendations are written in full, so they can be read alone.	The recommendations are written in full and can be read as standalone items.
3.5	Recommendations are measurable and outcome focussed.	The recommendations are measurable and outcome focussed.

Appendix D: Analysis of Trust's progress with the internal investigation action plan

Please note the recommendations are listed in the order of the Trust action plan (V9, October 2021) as opposed to the internal report (to facilitate cross referencing against the action plan). Please note recommendation 11 from the internal investigation report ("Trust to develop a process to ensure that MHTR documentation is shared with the CMHT"*) is not listed as a standalone recommendation in the Trust action plan provided to us but is combined with recommendation 5 below.*

Recommendations	
1	Community lead for quality and standardised practices to be identified.
2	Implementation of MaST caseload management.
3	Better identification and shared team understanding and management of the 'critical few' patients within a CMHT.
4	"*My supervision*" tool to be actively used during supervision.
5	Consider the development of a multi-agency hub to receive complex high-risk referrals for advice, support or action.
6	Trust-wide training and implementation of risk formulation.
7	"*Risk to others*" training for CMHT staff.
8	To develop specialised training in risk formulation for professional clinical staff.
9	The Trust to develop a risk assessment and management training module to form part of organisational induction and an annual mandatory refresher.
10	Care plans and risk assessments to be viewed as dynamic and live documents.
11	To develop a quality assurance framework to audit CPA care plans and risk assessment documents.

Rec	Action to address recommendation	Niche comment and assessment	
1	The deputy chief operating officer will develop the role and make it operational, having responsibility for the coordination of CMHT managers and addressing issues of quality and the standardisation of practices across the division.	We were informed the community lead for quality and standardised practices is now in post, but received no further detail (e.g., name or date of appointment). This role is responsible for coordinating community teams across the division. We were told the lead chairs monthly meetings with the community managers. We were provided with an (undated and without a title) example of a community meeting agenda. Within the agenda were four embedded documents, including community managers meeting minutes but we could not open these documents (at the time of writing we had not received a different version of the document). Managers are listed against agenda items, but in name only, their roles and team are not detailed. We were informed the meeting minutes are shared with the divisional service leads and operations meetings but did not see evidence of this. We were provided with several documents relating to the Community Excellent workstream (e.g., Community Excellent Programme blog post dated October 2021, and Community Excellence Network strategy group minutes, dated 20 October 2021. However, meeting attendees are listed by initial only, therefore it is not clear which groups/departments were represented at the meeting). The Community Excellent Report, September and October 2021, provides detail of achievements in relation to four project workstreams (pre-referral interface, managing referrals, meeting the need in the CMHT and communicating across the system). We have not seen evidence of how this information is communicated consistently across the division. We were provided with an agenda for the Local Division Programme of Change Steering Group, dated 22 June 2022 but not the subsequent meeting minutes. The broad agenda includes updates in relation to Community Excellence, CPA to Community Mental Health and MaST.	3

2	MaST to be operational across the local division.	The CCG provided a MaST end project report dated February 2020, supplied to them by the Trust as part of their own assurance process. The front cover template of the report (version control and approval) was incomplete. The report details the Trust's implementation of MaST. The main rollout of MaST took place between April 2019 and January 2020. The report provided detail of the number of staff trained by site (though the total number of staff is not provided therefore the percentage of staff training is unknown). It is noted that the MaST implementation was "*shortlisted for the Innovation Award at the Informatics Skills and Development Network Awards 2019 and the HSJ* [Health Service Journal] *Best Healthcare Analytics Award*". The report indicates use of MaST was to enter the 'business as usual' (BAU) phase in February 2020. We have received no detail of progress after this point. Community Excellence and MaST won an award for 'Innovation in Digital Mental Health' at the National Positive Practice in Mental Health Awards, 2021. We were provided with an agenda for the Local Division Programme of Change Steering Group, dated 22 June 2022 but not the subsequent meeting minutes. The agenda included an update about MaST. We told staff training takes place in one to one engagement sessions and an e-learning module. We were told MaST has been rolled out across all adult, older people and early intervention teams. We not provided with supporting evidence.	3
3	MaST to be operational across the local division.	MaST was implemented across the Trust and, as of February 2020, was moving towards it being BAU. The Trust provided an example (undated) of a supervision report which acts as a dashboard – monitoring compliance across clinical staff, divisions and services. The dashboard indicates relatively good compliance, but the report is undated. The Trust's Supervision Policy (2019) was revised to include a checklist for monitoring data quality and health record issues (Appendix A). We note the policy makes no reference to the MaST. We told staff training takes place in one to one engagement sessions and an e-learning module. We were told MaST has been rolled out across all adult, older people and early intervention teams. We not provided with supporting evidence (e.g., training attendance by specific group).	4

4	Agreed supervision tool to be used and monitored.	Please see above. In addition, the Trust has advised it is developing a new online site for recording supervision, which will include checklists. Supervision is monitored at the weekly safety huddle and via monthly report.	4
5	Service users who are highlighted as having complex needs and may also receive input from outside agencies (including MAPPA, H-RAMM, probation and/or hostels or supported accommodation) to receive care that is coordinated, with their risks effectively communicated and managed, with relevant documentation shared in a timely and appropriate manner, and with specialist support accessed if required. This includes the sharing of MHTR documentation with CMHTs.	The Trust advised of a project led by the clinical director and deputy chief clinical information officer. Centre for Perfect Care was to look at developing a panel to manage complex/high-risk service users. A pilot scheme was undertaken with a planned review in March 2020, but the Covid-19 pandemic delayed this meeting. We were told the workstream first developed into the Ethical Advisory Group but is now the Clinical Transformation Group (CTG). We were provided with the terms of reference for the CTG but no detail of forthcoming meetings. We were informed the CJLDT provide training in relation to clinical risk and 'dangerousness for staff' on request. Service users requiring additional input or specialist advice can be identified via MaST or the weekly safety huddle. We have received no detail of the original pilot or subsequent work undertaken in relation to this recommendation. There is no evidence that the sharing of MHTR information has been subject to review.	0
6	A Risk Assessment Working Group is established to ensure that robust arrangements are in place to support training, guidance and delivery of clinical risk assessments by the Trust and to develop a new training programme for staff.	The Trust has developed an effective risk intervention skills (eRISK) training package which launched in September 2020. It is supplemented with an eRisk learning handbook. The training has four modules: risk assessment, risk formulation, risk management, and safety plans. Staff competency will be assessed after training (four formative assessments and one summative assessment). Competency assessment should take place over the following year via supervision and reviews. We were provided with an eRISK training report for May-July 2022, detailing service uptake (and evidencing monitoring). The report sets out 90% of Local Division staff have received training. The report indicates some variation (beyond the local division) in training uptake. We were told training numbers are monitored by the weekly Safety Huddle and Trust wide Safe from Suicide team. We were also provided with details of the eRISK implementation plan and core team guide. It provides detail about training sessions, supporting guidance and access to relevant documents	4

7	Risk formulation training package to include harm to others module.	The Trust has an eRISK training package, which includes a module on risk formulation. We were provided with an eRISK training report for May – July 2022, detailing service uptake (and evidencing monitoring). We were told training numbers are monitored by the weekly Safety Huddle and Trust wide Safe from Suicide team.	4
8	A Risk Assessment Working Group is established to ensure that robust arrangements are in place to support training, guidance and delivery of clinical risk assessments by the Trust and develop a new training programme for staff.	We were provided with details of the eRISK implementation plan and core team guide. It provides detail about training sessions, supporting guidance, access to relevant documents, and competency scoring. The Trust eRISK training package has a module which covers risk formulation. We were provided with an eRISK training report for May-July 2022, detailing service uptake (and evidencing monitoring). We were told training numbers are monitored by the weekly Safety Huddle and Trust wide Safe from Suicide team.	4
9	A Risk Assessment Working Group is established to ensure that robust arrangements are in place to support training, guidance and delivery of clinical risk assessments by the Trust and develop a new training programme for staff.	The Trust has developed a comprehensive eRisk training package. We have not been provided with details of the staff induction programme (i.e., if this includes the eRISK package) or details of annual mandatory training compliance. [The action and update are the same as for recommendation 8 above].	3
10	Training above to ensure staff produce dynamic risk assessments and measure these via agreed competencies and supervision.	The action addresses the risk assessment element of the recommendation, but not the care planning. We were provided with detail of the eRISK training launched in September 2020. The training is supplemented by an eRisk learning handbook. The training covers risk assessment, formulation, management plans, and safety plans, and compliance with risk assessment standards will be monitored in supervision. A competency framework is included in the risk training. We were provided with an eRISK training report for May-July 2022, detailing service uptake (and evidencing monitoring). We were told training numbers are monitored by the weekly Safety Huddle and Trust wide Safe from Suicide team. We were provided with a clinical audit of CPA, dated May 2022. We were told CMHT managers monitor risk assessment completion and quality via clinical supervision.	2

11	Care plans to be regularly audited and assurance provided on the management of risk.	The Trust advised it has revised its CPA and risk policies, and provided information about changes to the CPA policy. There is evidence of audit activity e.g., CPA care planning 2018/2019. This audit details a review of 110 service user's records, against 12 standards. One standard extends to risk assessment. We saw no further evidence in relation to assessing the quality of risk assessments. Compliance against the CPA standards is variable, but the remit of our review does not extend to the detail of the audit findings. The Trust provided further CPA reports dated January 2021 and May 2022, demonstrating ongoing monitoring. The Trust launched eRISK training in September 2020 as part of the suicide prevention strategy 2020/21 but we have not seen details in relation to attendance/update. The four eRISK training modules are risk assessment, risk formulation, risk management plans and safety plans. The training guidance informs the user that, upon completion of the training, their risk assessment documentation will be assessment and compliance with the standard is built into 'your supervision'. A clinical risk competency assessment framework is embedded in the training. The Trust has developed frameworks to audit CPA care plans and risk assessment documents. However, we have seen limited evidence in relation to applying this to risk assessment.	3

Appendix E: Glossary

AMHP	approved mental health practitioner
BAU	business as usual
CCA	Care Coordination Association
CCG	clinical commissioning group
CDP	care delivery problems
CJLDT	Criminal Justice Mental Health Liaison and Diversion team
CJL	criminal justice liaison
CJMH	criminal justice mental health
CMHT	Community Mental Health team
CPA	Care Programme Approach
CPN	community psychiatric nurse
CTG	Clinical Transformation Group
CTO	Community Treatment Order
DRR	Drug Rehabilitation Requirement
EIT	Early Intervention team
FME	forensic medical examiner
GBH	grievous bodily harm
HQIP	Healthcare Quality Improvement Partnership
HSJ	Health Service Journal
ICB	integrated care board
IMHT	Integrated Mental Health team
MAPPA	Multi-agency Public Protection Arrangements
MaST	Management and Supervision Tool
MHA	Mental Health Act
MHCT	Mental Health Clustering Tool
MHTR	Mental Health Treatment Requirement
NPSA	National Patient Safety Agency
NQB	National Quality Board
PDU	probation delivery unit
PICU	psychiatric intensive care unit
PIP	Personal Independence Payment
RAR	Rehabilitation Activity Requirement
RCA	root cause analysis
SDP	service delivery problems
SI	serious incident
SIF	Serious Incident framework
SOP	Standard Operating Procedure
SpR	specialist registrar

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