An Independent Investigation into the care and treatment of a Service User

1 March 2013

ACKNOWLEDGEMENT

This is a report of the Independent Investigation into the care of Mr A by the Mental Health In-Reach Team ('MHIRT') at HMP Peterborough in the period leading up to the death of the Deceased on 11 September 2008.The Independent Investigation Team would like to extend its condolences to the Deceased's family and all those touched by his death.

This report focuses upon the potential learning for the MHIRT at HMP Peterborough in order to try to help reduce the risk of such a tragedy happening in the future.

The Independent Investigation Team recognises that a great deal of work has already been undertaken to improve services within the MHIRT. The Independent Investigation Team hopes that this report will give those involved in the delivery of secondary mental health care at HMP Peterborough a further opportunity to reflect upon how it can maximise the quality of the care which it delivers.

In undertaking this Investigation, Cambridge and Peterborough NHS Foundation Trust ('CPFT') has co-operated substantially with the Independent Investigation Team. The Independent Investigation Team is grateful for this assistance.

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1.0 EXECUTIVE SUMMARY

1.1 Introduction

1.2 On 11 September 2008, Mr A, an inmate of HMP Peterborough, was involved in an assault on a fellow inmate at the prison (the 'Deceased'). A number of other prisoners were involved in this assault. The Deceased died following the assault as a result of his injuries in association with heart disease. Mr A was subsequently convicted of the manslaughter of the Deceased.

1.3 At the time of the assault, Mr A and another inmate who was connected with the assault had been in contact with the Mental Health In Reach Team at HMP Peterborough (the 'MHIRT').

1.4 Mr A was a complex individual. He was displaying characteristics of a potential personality disorder when he sought help from the MHIRT. However, his presentation included symptoms which were suggestive that the diagnosis could have been more complex. Mr A was not subjected to a proper diagnostic process in order to assess his complex problems. He did not undergo a risk assessment process by the MHIRT.

1.5 It is the view of the Independent Investigation Team that there were a number of missed opportunities in the care of Mr A. Whilst these opportunities would not have made the death of the Deceased preventable or indeed predictable, identifying additional learning points provides a continuing opportunity for CPFT to examine the operation of the MHIRT in order to ensure that the care which it provides to prisoners in HMP Peterborough is of an acceptable standard.

1.6 The delivery of good quality care depends upon the effective interaction of three key elements. Firstly, the regulatory structures and clinical standards which apply to organisations in the NHS dictate standards in relation to a number of aspects of care delivery. In a Mental Health In Reach setting, these include a number of diverse bodies such as MONITOR, HM Inspector of Prisons and the Care Quality Commission (the 'CQC'). These bodies seek to ensure that organisations are transparent and can account for their performance and actions. They can take action when local organisations fail to resolve issues. However, these bodies are not responsible for 'micromanaging' healthcare providers. The clinical standards that these organisations promote come from the shared learning provided by bodies such as the National Institute for Clinical Excellence ('NICE').

1.7 The second element relates to the quality of leadership provided by the Boards of health care providers. They are responsible for ensuring the quality of care delivered by their organisation and are ultimately accountable when things go wrong. In order to secure this objective, they must be in a position to monitor the quality of care provided and then take action to resolve issues which arise due to poor systems or processes.

1.8 The third, and in a number of respects the most important element, is the professionals, both clinical and managerial, who deliver care directly to patients. These individuals are responsible for their own professional conduct and competence and for the quality of the care they provide. However, they are also observers who as committed professionals have views upon the quality of service delivery and ways in which it can be improved. In order to maximise the potential of the key role which these individuals play it is vital that a culture of openness exists. Establishing such a culture is a key function of an effective Board and management team.

1.9 The MHIRT at HMP Peterborough was established in 2005 when the Prison opened. HMP Peterborough underwent its first inspection in 2006 and was criticised in relation to a number of areas by HMP Inspector of Prisons, including the provision of primary health care.

1.10 In common with other teams around the country at that time, the MHIRT at HMP Peterborough was established by committed individuals who had not previously worked in a prison environment nor been responsible for establishing a new service that included the necessary governance systems to ensure that appropriate care could be delivered. At CPFT Board level there was a similar lack of experience of the complex challenges posed by the mental health needs of a prison population and the delivery of health care in a custodial setting where, for example, priorities such as security and safety can clash with clinical priorities in a way that does not usually happen outside prison.

1.11 The prevalence of serious personality disorders, drug and alcohol dependence, suicidal and self-harming behaviour, and all forms of mental illness is much higher in a prison population than in the general population. The MHIRT at HMP Peterborough was faced very quickly with a heavy case load of some very vulnerable and mentally unhealthy individuals.

1.12 The MHIRT was isolated from CPFT and the other prisons for which CPFT was responsible. For example, there was no computer link between the MHIRT and CPFT which would allow MHIRT members to access the CPFT's intranet containing the policies and procedures which practitioners and staff were required to follow.

1.13 There were significant funding issues between CPFT and its commissioning PCT in relation to the provision of care and a robust Service Level Agreement ('SLA') was not in place at the time of the Deceased's death. The Board did not set out clear targets or prioritise care needs to assist the MHIRT in carrying out its duties, and appears to have lacked a strategic approach towards the service due in part to a lack of management information being requested or provided by the MHIRT. The MHIRT also experienced a high turnover of senior management members, depriving the MHIRT of consistent leadership.

1.14 Given the demands of its case load, the MHIRT was forced to make compromises in relation to its workload. The Independent Investigation Team understands that services were established from a resource-led focus rather than as a result of a needs-based analysis. In addition, the resources available did not meet the needs which existed in the prison at that time. This led to a very difficult working environment in which dedicated professionals struggled to provide a service in the face of underfunding. This was exacerbated by a lack of strategic leadership which would have allowed needs within the service to have been properly identified and prioritised, facilitating meaningful discussions concerning the allocation of services.

1.15 Understandably, the day to day care of prisoners was given greater priority than the establishment of clinical governance systems and processes. At the time of the Deceased's death in September 2008, the MHIRT did not have a clinical governance system which was fit for purpose. This had a direct impact upon the quality of care which Mr A received from the MHIRT.

1.16 Mr A was not the subject of clinical review by a qualified member of the MHIRT. However, Mr A presented with a number of complex problems, including substance misuse.

1.17 In sentencing Mr A in relation to the Deceased's death, the Judge accepted that Mr A presented with *'features of emotionally unstable personality disorder, border line[sic] type'*. The Judge took the view that there was no evidence which suggested that Mr A was suffering from schizophrenia. The Judge accepted that it had not been Mr A's intention to kill the Deceased, but instead to give him a violent warning.

1.18 Mr A's presentation, whilst complex, is not an unusual one within a MHIRT setting. The prison population includes a disproportionate number of individuals who have a personality disorder compared to the prevalence of such disorders in the general population. Indeed, it is estimated that approximately 2/3 of the prison population would meet the criteria for a diagnosis of personality disorder.

1.19 Personality disorders are recognised mental disorders. Antisocial and borderline personality disorders are common in criminal justice settings. However, individuals with personality disorders often face discrimination within a prison healthcare setting. Pervasive attitudes among clinicians, health care administrators and policy makers perpetuate the marginalisation of people with personality disorders within systems of mental health care. Patients with a personality disorder may not be regarded as suffering from a 'legitimate' illness by some and accordingly viewed as a drain on resources (a view not held by the Investigation Team). Lack of suitable mental health services may be rationalised based on these attitudes. Similar difficulties occur for individuals who present with substance misuse problems in terms of access to health care.

1.20 It is the Independent Investigation Team's view that Mr A's presentation warranted further investigation in order to exclude mental illness. Further, investigations as to a potential Axis I or Axis II diagnosis would have been justified by his presentation. This could have allowed a strategy to be determined relating to the management of the risks associated with Mr A's mental health problems.

1.21 Mr A was referred to the MHIRT on a number of occasions but was not able to access care. The Independent Investigation Team is concerned that this may in part have been because a diagnosis of personality disorder excluded Mr A from the definition of 'severe and enduring mental illness' applied by the MHIRT at the time. Personality disorder is, however, a recognised mental health disorder and is also 'severe' and 'enduring', albeit not by convention regarded as an illness. Indeed, forward-thinking psychiatrists, such as the late Professor Robert Kendell, have questioned the distinction made between personality disorder and mental illness.

1.22 At the time of the Deceased's death, the MHIRT did have a psychologist with a special interest in personality disorder on its team. However, despite Mr A being referred to the Team at a time when new referrals were intended to be discussed in a multidisciplinary setting at the weekly team meeting, Mr A's case was not brought to this forum. Instead, he was assessed by an unqualified member of the Team acting

on the instructions of a Team Manager outside a clinical governance structure which was in place at the time.

1.23 Mr A was screened upon Reception at HMP Peterborough on 4 August 2007 by a healthcare assistant. During his assessment, Mr A revealed that he had been admitted to a psychiatric unit in 2005. He also advised the healthcare assistant that he had substance misuse issues. Mr A was subsequently referred to the MHIRT, although the referral process is unclear.

1.24 On 21 September 2007, a number of background checks on Mr A were carried out by the MHIRT. These checks purportedly showed that Mr A was not known to mental health services. The nature and extent of these checks are not included in Mr A's records. Mr A's records show that the MHIRT suggested his referral to CARATS.

1.25 On 29 September 2007, Mr A's records show that he had asked to see a psychiatrist due to sleeping difficulties. Further on 13 October 2007, Mr A's notes record a further incidence of self-harm when Mr A inserted a 2.5 cm length of wire into his abdomen. Mr A was sent an MHIRT appointment for 18 October 2007. Further background checks were undertaken in advance of this appointment. The MHIRT again reached the view that Mr A was not known to mental health services in the area.

1.26 Mr A did not attend his appointment with the MHIRT on 18 October 2007. In line with MHIRT policy at that time he was not offered a further appointment. The MHIRT received a letter from Mr A's solicitors on or around 12 November 2007 advising that a judge involved in sentencing Mr A had asked that a psychiatric report dated 26 February 2004 be taken into account in his future management. The MHIRT response to this letter was that Mr A had failed to attend an appointment with the service. He was therefore responsible for seeking a further appointment with the service through his wing officer.

1.27 The Independent Investigation Team do not believe this was an appropriate response due to the complexity of Mr A's presentation revealed in the Psychiatric report dated 26 February 2004. The Independent Investigation Team believe that Mr A should have been offered an appointment with the MHIRT psychiatrist at this time or should have had his care discussed in a multidisciplinary context.

1.28 On 22 February 2008, Mr A was seen by a health care worker outside the MHIRT. Mr A was complaining of symptoms of depression. Mr A was not referred to the MHIRT but was instead offered anti-depressant medication.

1.29 Further, on 17 March 2008, Mr A attended an appointment with a prison health care worker. On this occasion, Mr A again asked to see a psychiatrist. Both of these appointments involved Mr A being assessed by individuals who were not qualified and who would not have been able to assess the importance of the symptoms exhibited by Mr A when placed in the context of the psychiatric report referred to at Paragraph 20.19 below, even if that report had been available to them.

1.30 Mr A was referred to the MHIRT by CARATS on 23 July 2008. Mr A was seen on two occasions by Substance Misuse Practitioner 1, a substance misuse practitioner working within the MHIRT (14 August 2008 and 8 September 2008). Substance Misuse Practitioner 1 was asked to see Mr A with a view to assessing whether he required care from the MHIRT. This request was not appropriate because Substance Misuse Practitioner 1 was unqualified. In addition, Substance Misuse Practitioner 1's case load was not the subject of formal supervision. This is unacceptable and potentially dangerous practice. The Independent Investigation Team have been advised that Substance Misuse Practitioner 1 no longer carries out mental health assessments. She now undergoes supervision in accordance with CPFT policies and procedures.

1.31 The MHIRT had in place a weekly multidisciplinary team meeting at the time of Mr A's care. New referrals could be discussed at this meeting. Mr A's care was not discussed despite two individuals involved in Mr A's 'referral' being present at meetings during this period of his care by MHIRT. At the time when the MHIRT was trying to establish the true nature of its case load due to difficulties with its referral processes and pathways, Mr A's name was omitted from the MHIRT's database. A manual system has now been introduced to capture referral and discharge information.

1.32 Mr A's psychiatric needs were complex. His needs fell within the eligibility criteria outlined in the MHIRT's Operational Policy dated September 2005. However, his needs did not receive a proper clinical evaluation.

1.33 Substance misuse can indicate a degree of 'self-medication' by individuals who are experiencing issues relating to a personality disorder. A full clinical evaluation is necessary to reach such a diagnosis and devise an appropriate treatment plan. If a substance misuse problem is seen in isolation, important diagnostic information may be missed.

1.34 HMP Peterborough has introduced an Integrated Drug Treatment Service ('IDTS') since Mr A's care. This is an element of good practice. The MHIRT and IDTS operate a joint clinic run by a dual diagnosis nurse working for IDTS and a substance misuse practitioner. However, the relationship between the IDTS and MHIRT is not the subject of a formal protocol. This is an important control weakness. The Independent Investigation Team is concerned that the position responsible for providing the link between IDTS and MHIRT is held by an unqualified individual. The Independent Investigation Team have been advised that *'CPFT will review this working arrangement and will produce a joint working protocol in partnership with HMP Peterborough's IDTS team.'*

1.35 Additionally, the MHIRT has introduced Alert Clinics to increase access to its services. This is an element of good practice and addresses an issue of accessibility arising out of Mr A's care. When a patient is seen in an Alert Clinic, information is gathered on that individual which is then discussed in the MHIRT meeting. This ensures a degree of multidisciplinary working. However, the processes surrounding the Clinics are only now being formalised after twelve months of operation and have not been incorporated into the draft Operational Policy provided to the Independent Investigation Team. Written procedures, whilst being less flexible, do have the advantage of clarity for those involved in delivering the service. There is less room for misunderstanding and consistency is more readily obtained. It also assists in the current audit process. There has also been a lack of formality in a number of key relationships and processes which the MHIRT has now adopted.

1.36 Risk management and management of the propensity for violent behaviour are a crucial aspect of the role of MHIRTs, as well as the prison establishment and the National Offender Service ('NOMS'). There are a number of commonly available risk assessment tools in the criminal justice system including the OGRS-2, HCR-20 and OASys. In 2008, MHIRT staff were not trained in the use of HCR-20. All staff now receive training. This is an element of good practice and learning which flows from the Internal SUI Report 146/2008.

1.37 Mr A was not the subject of a standard CPA risk assessment or a formal risk assessment by the MHIRT. Given the complexity of his presentation and the information which was available to the MHIRT, this is a cause for concern. The Independent Investigation Team understand that *'risk assessment is now carried out on all In-Reach patients as they enter the service and reviewed at agreed intervals. This is embedded in practice and enshrined in policy (app 4). HCR 20 risk*

assessment training is one of our mandatory training requirements for In-Reach clinicians.'

1.38 A significant amount of investment has been made by CPFT into revising and strengthening its CPA processes. Innovative programmes have been developed to enhance the CPA process. The Re-Review of Prison In-Reach Services completed in July 2012 noted that emphasis had been placed on recording and auditing CPA information but that ongoing alteration was necessary to ensure that they were relevant to the prison environment. The Independent Investigation Team believe that there would be substantial benefit to these programmes being adapted for the prison environment and implemented with immediate effect.

1.39 Risk management processes within the MHIRT, including the operation of the newly formed Risk Supervision Group, have not been fully formalised. The development of the Risk Supervision Group displays an attempt by the MHIRT to embed good practice. However, the lack of written processes with regard to some aspects of the operation of the MHIRT is a matter of considerable concern for the Independent Investigation Team. Lack of formalised written processes can lead to differences in understanding which in turn can cause weaknesses in clinical governance arrangements and structures. This mirrors the lack of formality of process which was present at the time of the Deceased's death and is a matter of significant concern for the Independent Investigation Team.

1.40 The process of information management within prisons can be problematic. Effective risk management depends upon access to information from a variety of sources. At the time of the Deceased's death, the MHIRT was not connected to CPFT's computer systems. This hampered the MHIRT's attempts to establish Mr A's previous medical history. This link was put in place in August 2009 and MHIRT members have access to all CPFT clinical governance policies and procedures and the electronic care records of patients.

1.41 The MHIRT now has greater access to the prison's computer system which will assist in the identification of information which is relevant to individual prisoners care and risk assessment. This is an element of good practice. However, the Independent Investigation Team believes that there remains an unacceptable level of informality in the MHIRT's approach to the flow of information. For example, the MHIRT do not have a protocol or process for the receipt of information concerning a prisoner from the court or the prisoner's solicitors, despite this being highlighted as an issue in relation to the care of Mr A. The Independent Investigation Team have been advised

that the MHIRT will in future *'ensure a consistent process described in protocol and adopted by the team. It should be noted that the team meets daily to review the Prison's 'morning sheet' to review any incidents which took place overnight.'*

1.42 Individuals working in the prison environment have a tendency to work in isolation from other professionals who might provide valuable input into a patient's care and treatment plan. In order to deliver the best care and accurately establish risk, it is necessary to have as wide a picture as possible of the patient. This can be partly achieved by reviewing the pathways through which information flows. At the time of writing CPFT is introducing a new electronic care record system (RIO) to allow consistent access to mental health records by healthcare professionals within CPFT. This will help link up previous health care notes for treatment received within CPFT. However, this will not help link up health with other information from the prison, e.g. wing information, probation and security, or indeed care received by patients in Trusts other than CPFT.

1.43 An external Review (the 'Review') of the MHIRT was conducted in May 2009. The Review was detailed and made recommendations which were designed to significantly strengthen clinical governance arrangements within the MHIRT. Following the Review, CPFT made a substantial investment in the MHIRT which is an element of good practice. A follow-up Review, as envisaged by the external Review, was completed in July 2012.

1.44 Information was handed to the CPFT management team regarding the Deceased's death on 17 September 2008. Two MHIRT patients were involved in the attack on the Deceased. The issues arising from Mr A's care at that time were said to be:

- Lack of risk assessments;
- Loose practices in closing files;
- Lack of clarity concerning Mr B as to whether he was receiving care from the MHIRT;
- Role of Substance Misuse Practitioner 1 was unclear; and
- Poor records.

1.45 An initial report was compiled on 24 September 2008. The Initial Report was compiled using Mr A's records and those of Mr B.

1.46 The Initial Report was not compiled in accordance with Trust Policy or in accordance with NPSA Guidance. However, it did contain some elements of good practice. In

particular, the Initial Report recognised that a more in depth investigation was necessary in order to establish whether the contact which the MHIRT had with Mr A or Mr B was relevant to the death of the Deceased. Further, it identified that pathways were unclear and that there were difficulties in identifying whether a service user was in receipt of care from the MHIRT.

1.47 Consultant Psychiatrist 5 and Consultant Psychiatrist 7, two consultant psychiatrists working for CPFT, wrote to the Director of Adult Specialist Services at CPFT on 6 February 2009 raising concerns about the care of Mr A and Mr B. They asked why the death of the Deceased had not been reported as an SUI which would have allowed the matter to be reviewed internally. A number of other concerns were raised by the consultant psychiatrists relating to poor clinical governance practices within the MHIRT.

1.48 A meeting took place with members of the senior management team on 7 April 2009. Following this meeting the Review of the MHIRT was commissioned.

1.49 The Deceased's death was not recorded on the DATIX system until after a meeting was held on 10 September 2009. Despite persistent attempts by Consultant Psychiatrist 5 to ensure that the Deceased's death was registered as an SUI with CPFT and for that SUI to be registered and investigated internally, it was not until 11 March 2010 that a draft SUI report was prepared for circulation.

1.50 There appears to have been confusion within the Board of CPFT as to the criteria and processes necessary to undertake an SUI investigation. It appears that it was felt necessary that a conviction should occur prior to any internal investigation being commenced. This caused delay.

1.51 CPFT has experienced a significant level of criticism in relation to how it investigates SUIs. The CQC has been critical of it. CPFT's response initially was to commission a number of reviews which confirmed the problem. A new policy concerning SUIs was introduced entitled 'Near Miss, Incident and Serious Incident (SI) Policy and Procedure' in February 2011.

1.52 In relation to the death of the Deceased, the management team of the MHIRT initially acted slowly but appropriately in reporting the Deceased's death to the Board of CPFT. Difficulties appear to have arisen at Board level which may have prevented the Deceased's death being investigated promptly and effectively. This is a concern because it is the Board which establishes the culture of an organisation and the

failure to initiate an investigation of this nature suggests an inadequate cultural approach towards safety. The Independent Investigation Team accept that there have been significant changes to the membership of the Board of CPFT since the Deceased's death, which will impact upon the culture of the organisation.

1.53 The Independent Investigation Team are also concerned that Consultant Psychiatrist 5 was forced to take steps to have the death of the Deceased investigated and indeed in doing so invoked the whistle blowing procedure available to all employees.

1.54 The Internal Investigation which was eventually performed by CPFT in relation to Mr A's care was at best 'cursory'. Whilst it is acknowledged that a significant number of changes had taken place in the governance regime of the MHIRT, the Internal Investigation did not seek to fully establish what had been the issues involved in Mr A's care. Indeed, the Internal Investigation did not pick up issues highlighted in the Initial Report into the death of the Deceased, such as the difficulty in establishing a proper case load, in order to check that this learning point had been accepted and dealt with. This is a cause for concern.

1.55 The Independent Investigation Team is of the view that it was predictable that Mr A could behave violently. The Independent Investigation Team does not believe that it was predictable that Mr A would behave so violently that he would kill someone unless there was an independent contributory factor such as, which was the case here, pre-existing heart disease. The Independent Investigation Team does not believe that the Deceased's death was preventable by members of the MHIRT.

1.56 The Independent Investigation Team has made a number of recommendations, the purpose of which is to capture the learning from its examination of Mr A's care. Those recommendations are set out at Section 28 of this report.

2.0 INTRODUCTION

2.1 On 11 September 2008, Mr A was an inmate of HMP Peterborough when he and number of other prisoners were involved in an attack on a fellow prisoner (the 'Deceased').

2.2 Six prisoners were identified as being involved in what was a concerted assault on the Deceased. They were arrested and initially charged with murder. The charges were later reduced to manslaughter following post mortem examination. Post mortem examination showed that the Deceased died as a result of *'Blunt force injury to head and face in association with underlying Ischaemic heart disease'*. It was the pathologist's opinion that the stress of the assault had precipitated a fatal cardiac dysrhythmia in the face of significant underlying ischaemic heart disease.

2.3 One prisoner admitted his involvement in the events leading up to the Deceased's death. However, the other five, including Mr A, denied involvement and were put on trial for manslaughter. On 23 December 2009, three of the co-defendants were acquitted while two, including Mr A, were found guilty.

2.4 The jury accepted that it had not been the prisoners' intention to take the Deceased's life, but that they had instead intended to issue him a 'violent warning'. The attack was sparked by prisoners' resentment concerning the Deceased's drug and tobacco dealing.

2.5 Two of the prisoners arrested in connection with the events leading up to the Deceased's death were known to the Prison Mental Health In Reach Team ('MHIRT') at HMP Peterborough, Mr A and Mr B.

2.6 Prosecuting counsel alleged that a decoy system had been set up to facilitate the attack. Mr B, who suffers from epilepsy, was said to have been the decoy and it was alleged that he pretended to have a fit to attract the attention of prison officers. Mr B was acquitted of the charge of manslaughter at his trial.

2.7 During the course of his trial, Mr A admitted that he had entered the Deceased's cell but said that this had been in order to purchase drugs or alcohol and that he had nothing to do with the violence which occurred. Mr A was convicted of manslaughter and received a prison sentence of four years and six months.

3.0 INDEPENDENT INVESTIGATION

3.1 Iodem Health Limited has been commissioned by NHS Midlands and East (the 'SHA') to undertake an Independent Investigation into the care and treatment of Mr A in the period leading up to the death of the Deceased. The Independent Investigation has been conducted in accordance with HSG 94 (27), Department of Health Guidance. This refers to the circumstances in which:

> *'…a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.'*

3.2 The purpose of an Independent Investigation is not to apportion blame but to promote learning in an attempt to improve the delivery of services so as to reduce the risk of a similar event occurring in the future.

3.3 Independent Investigations conducted in accordance with HSG (94) 27 are entirely separate from the legal processes that take place following a homicide. The aim of such Investigations is not to investigate the circumstances of the death, but is instead to enable the providers of care to learn lessons and make improvements for the benefit of future service users, their carers, and the public.

3.4 Consequently, the principal purpose of the Independent Investigation into the care of Mr A is to provide the SHA with clear recommendations about what action it needs to take to maximise learning from this case and ensure that it is used to improve mental health services delivered by the MHIR Service at HMP Peterborough, a service provided by CPFT.

3.5 However, the Independent Investigation Team recognise the added public interest in ensuring that the full facts of Mr A's care are brought to light when the circumstances surrounding a patient's care could impinge upon a death in custody. This is important in order to ensure that practices and procedures have been rectified.

3.6 Following the Deceased's death, CPFT carried out an Internal Investigation into Mr A's care which resulted in an action plan to address a number of issues which the Internal Review Team (the 'IRT') highlighted. In addition, the Independent Investigation Team was advised that the MHIRT has been the subject of significant re-organisation and investment by CPFT.

3.7 The focus of this Independent Investigation has therefore been upon ensuring that the systems and processes which have now been introduced by CPFT following the

death of the Deceased enhance the care of current and future service users of the MHIRT.

4.0 THE INDEPENDENT INVESTIGATION TEAM

4.1 The Independent Investigation was carried out by the following three individuals who are unconnected with CPFT and the SHA:

- Janet Hawthorne LLB (Hons) - Lead Investigator, Regulatory Lawyer
- Dr Keith Rix - Consultant Forensic Psychiatrist
- Dr Tracy Carlson – Clinical Psychologist

4.2 Biographies of the Independent Investigation Team are attached at Appendix A.

5.0 TERMS OF REFERENCE

5.1 The following Terms of Reference were agreed with the SHA for the Independent Investigation. It was envisaged that the Independent Investigation was to be carried out in two stages and conducted in accordance with the National Patient Safety Agency Good Practice Guidance for Independent Investigations. The full Terms of Reference of the Independent Investigation are set out at Appendix **B**.

5.2 The Independent Investigation was conducted in two stages:

5.3 Stage 1

Following the review of clinical notes and other documentary evidence:

- Review the Trust's Internal Investigation (SI Ref Number: 146/2008 (the Deceased) V.8) and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.

5.4 Stage 2

- Review the care, treatment and services provided by the Team, from the service user's first contact with the Team to the time of the Offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment, care and supervision of the mental health service user by the Team in the light of any identified health 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 himself or others during the period between first referral to the Team and the date of the Offence.
- Examine the effectiveness of the service user's care plan including the involvement of the service user.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations applicable to the Team.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the SHA that includes measurable, relevant to the current clinical environment and sustainable recommendations with a view to preventing a recurrence.

6.0 METHODOLOGY

6.1 During the initial stages of the Investigation, the Independent Investigation Team gathered documentary evidence relating to Mr A. The following documentary information and records concerning Mr A's care were obtained:

- Clinical records maintained by CPFT;
- CPFT Policies and Procedures relevant to Mr A's care;
- Psychiatric reports relating to Mr A which were prepared for criminal proceedings; and
- Additional documentation obtained from witnesses to the Investigation.

6.2 These documents were used to form the basis of the Investigation and plan subsequent interviews with key participants in Mr A's care.

6.3 The Independent Investigation Team were able to interview the main participants in Mr A's care. A total of 6 witnesses were interviewed by the Independent Investigation Team. The interviews were held between 18 January 2012 and 25 April 2012. Where necessary, each interviewee was provided with a copy of the Independent Investigation's Terms of Reference and a bundle of relevant documentation prior to their interview.

6.4 The majority of witness interviews were attended by the Investigation Team Leader together with one other member of the Independent Investigation Team. To ensure the interviews were targeted, credible and insightful, the expertise of the Independent Investigation Team member was linked to the area of work and expertise of the interviewee.

6.5 The interviews were transcribed from NEAL recording equipment. Following their interview, each interviewee was given a copy of the transcript of their interview and was asked to correct any errors of transcription or to add anything they felt had been omitted. The transcripts were then sent to all Independent Investigation Team members to review.

6.6 Following the interviews, the Independent Investigation Team discussed and reviewed the information gathered, identified and analysed the issues and prepared this report.

6.7 In carrying out this Investigation, the Independent Investigation Team have taken care to remain objective and impartial, whilst being mindful of the devastating impact which the attack upon the Deceased has had upon his family and friends.

6.8 The benefit of hindsight can introduce unfairness into any investigation. Hindsight bias occurs when people who know the answer overestimate its predictability or obviousness, compared to the estimates of those who must guess the outcome without advance knowledge. The Independent Investigation Team have remained acutely aware of the danger of hindsight bias throughout the Investigation and has tried to recognise its impact and correct it when possible.

7.0 INVOLVEMENT OF VICTIM'S FAMILY AND PERPETRATOR

7.1 Involvement of Mr A

7.2 At the start of this Investigation, Mr A was contacted by the SHA in order to obtain his consent for the Independent Investigation Team to access his clinical records. On 25 March 2011, Mr A signed a consent form giving the Independent Investigation Team full permission to access his clinical records.

7.3 Communication with the Deceased's family

7.4 Communication with the Deceased's family was conducted through Cambridgeshire Constabulary. The Deceased's partner initially expressed the view that she would be prepared to talk to the Lead Investigator from the Independent Investigation. The Lead Investigator wrote to the family, but did not receive a response. The Independent Investigation Team respected this decision and did not make any further contact with the family.

8.0 ATTACK ON BH

8.1 Three members of staff were on duty on X2 wing, where the Deceased's cell was, on 11 September 2008. CCTV footage taken just before 7.50pm on 11 September 2008 shows a prisoner, Mr B, walking down one of the two stairways leading from the upper landing to the lower landing.

8.2 This was the stairway at the end of the landing furthest away from the Deceased's cell. When Mr B reached the bottom of the stairs, he collapsed, apparently suffering an epileptic fit. A number of prison officers and a prison nurse went to Mr B's assistance. This left the upper landing unstaffed by prison officers.

8.3 Meanwhile, the CCTV footage shows several prisoners from the upper landing leaning over the banister rails. At the point when all three prison officers were attending to Mr B, four prisoners from the upper landing went into the Deceased's cell.

8.4 One of the four left very soon afterwards, but the other three, including Mr A, remained in the cell for several minutes.

8.5 At around 8.10 pm staff began to lock-up prisoners for the night. When a prison officer checked on the Deceased he found him slumped in his cell, propped up against a wall. His cell was in disarray. The Deceased could not be roused and resuscitation attempts were made. An ambulance was called.

8.6 The prison officers who were called to assist with the Deceased noticed bumps and bruises on the Deceased's face and were able to reach the conclusion that the Deceased had been beaten.

8.7 The local police force is routinely informed about every death in prison custody. The police visit the prison and examine the scene where the death occurred. When the CCTV footage was viewed, it showed several prisoners going into the Deceased's cell together at the point in time that the wing officers were attending to the prisoner who had collapsed on the lower landing. Prison staff identified for the police the prisoners who were apparently involved. The police interviewed those prisoners as well as others who it was believed might be witnesses.

8.8 HMP Peterborough's then Director, Mr Mike Conway, gave a briefing to staff that night. Two members of the Samaritans were called into the prison the following day in order to provide support to prisoners and staff.

8.9 Key Points

1. The attack on the Deceased involved a group of prisoners, of which Mr A was one.
2. Mr B was a prisoner who acted as a decoy during the attack on the Deceased.
3. The Deceased was beaten during the attack.

9.0 HMP PETERBOROUGH

9.1 HMP Peterborough is a Category B local prison separately holding male and female prisoners and is a designated Young Offenders Institution for young women. The prison is privately operated by Sodexo Justice Services (formerly Kalyx). The prison opened on 28 March 2005.

9.2 Operational Capacity

9.3 HMP Peterborough has an operational capacity of 840 (480 men, 360 women). Due to overcrowding it housed on average 950 prisoners between 2006 and 2012. Most of the overcrowding occurs within the male prison.

9.4 Provision of Medical Services within the Prison

9.5 Sodexo provided 24-hour primary care nursing services on a long-term contract with the Ministry of Justice as part of a private finance initiative.

9.6 Mental health services are now provided by CPFT. At the time when Mr A received care, CPFT provided only secondary mental health services to HMP Peterborough.

9.7 At the time Mr A received care, Cimarron UK, a General Practitioner ('GP') locum agency, provided primary care services to the Prison.

9.8 Prisoner Profile

9.9 A profile of the prison population of HMP Peterborough is contained in a report on an Announced Inspection of HMP Peterborough (Men) in 2011 by HM Chief Inspector of Prisons. This report shows that 68% of HMP Peterborough's prisoners had been sentenced. 14% of prisoners had been convicted but were unsentenced at the time that the report was compiled and 17% of prisoners were remanded in custody awaiting trial. In addition, HMP Peterborough has a high throughput of men serving sentences of less than 12 months. The prevalence of mental disorders in this population profile is high and presents the prison and those providing medical services for the prisoners with a number of specific challenges.

9.10 In June 2011, the Prisons and Probation Ombudsman (the 'PPO') produced a report entitled 'Learning from PPO investigations: Self-inflicted deaths in prison custody 2007-2009'. This report analysed data from over 200 self-inflicted deaths which took place in prisons across the country and confirmed that remand prisoners and recently imprisoned prisoners account for the greatest proportion of self-inflicted deaths.

Nearly half of all the prisoners were not sentenced at the time of death (unconvicted 41%, convicted but unsentenced 7%).

9.11 Current national prison policy is for all new prisoners to be screened by a hospital officer on the day of their arrival and subsequently by a prison medical officer. The prison doctor usually sees the prisoner the next working day as part of the prison induction process. However, nationally, the effectiveness of health screening by prison medical staff has been questioned. Prison conditions and time constraints do not ensure the detection of clinically important information. In addition, some prisoners can present with communication or behavioural issues which may not assist the diagnostic process and indeed may be regarded as a discipline issue rather than a medical issue. A further contributory factor may be the quality of training which prison staff receive. In a prison which has a high turnover of prisoners, these problems may be exacerbated.

9.12 Failure to identify mental health disorders in those entering prison means that an opportunity for intervention is lost. This is a significant missed opportunity because these individuals might not come to the attention of mental health services by any other route.

9.13 Key Points

1. HMP Peterborough is a Category B local prison.
2. The prison opened on 28 March 2005.
3. At the time of the Deceased's death, CPFT provided secondary mental health services to the prison.

10.0 PRISON INSPECTORATE REPORTS

10.1 HMP Peterborough has been the subject of a number of reports by HM Inspector of Prisons. The prison was inspected for the first time in 2006 when it had been open for 18 months. The male and female prisons are inspected separately. Mr A was an inmate of the male prison and therefore the Independent Investigation Team has concentrated on inspections of the male facility.

10.2 The Independent Investigation Team believes that the reports prepared following inspection by HM Inspector of Prisons are important in providing an understanding of the prison regime which operated at the time that each report was prepared in order that Mr A's care and the operation of the MHIRT can be looked at in the context of the wider prison environment.

10.3 Inspection Report October 2006

10.4 In 2006, reports prepared by HM Inspector of Prisons into both the female and male facilities at HMP Peterborough were highly critical.

10.5 In particular, it was noted in relation to the provision of healthcare that:

> *'One of our main concerns was the provision of healthcare, which was among the worst we have seen for some considerable time. At every level from the administration of medicines, through to primary and in-patient care there were serious deficiencies, with under-trained and inadequately managed healthcare staff unable to provide a safe and decent service. These defects were so serious that we called in senior managers from Kalyx and the NHS to take immediate remedial action.'*

10.6 Individual criticisms included the following:

> *'4.1 Health services delivery by Peterborough Primary Care Trust were poor and needed urgent remedial action. Record-keeping was poor and fragmented. Many locum GPs were used with a consequent lack of continuity and quality of care for prisoners. The Mental Health In-Reach Team managed its own case load and coordinated mental health transfers, with no clear identifiable lead on mental health in the primary care team to liaise with.'*

> *'4.9 Clinical governance arrangements were limited and it was not clear how the prison fitted into PCT arrangements. There was a prison draft clinical governance action plan but no evidence that it had been adopted by prison health services staff.'*

10.7 In relation to the mental health services, the Inspection Report included the following comments:

> *'4.64 Mental health services were provided by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. The core team consisted of a team leader and two in-reach nurses (one designated to the men's prison), a consultant psychiatrist who visited once a week, a forensic psychologist who attended once a week and an assistant clinical psychologist four days a week (this post was vacant and being recruited). A full-time administrator was also employed. There was no clearly identifiable mental health link nurse on the primary care team.'*

> *'4.66 Referrals to the in-reach team were made only through the primary care team. Routine referrals were seen within a week, with urgent referrals seen on the same or following day (except at weekends). A standard consent form was completed and information sought from outside sources. Any care programme approach (CPA) started before reception was continued and community staff were invited to visit the prison. Contact was made with community services for this group of prisoners before planned release. It was not possible to determine the current case load of this service. Separate clinical records were maintained by the in-reach team, with a summary entered in the main electronic clinical record. The in-reach team coordinated mental health transfers from the prison.'*

10.8 Inspection Report October 2008

10.9 Due to the concerns highlighted in its initial report, an unannounced short follow-up inspection of HMP Peterborough took place in June 2008. In relation to healthcare, the Inspectors took the view on this occasion that:

> *'Healthcare had improved, but there remained much to be done, and primary mental health services were under-resourced.'*

10.10 In particular, it was noted that:

> *'HP10 There had been considerable improvement in clinical services for men with substance use problems and in psychosocial treatment, but the strategy would have benefited from a formal needs assessment. Clinical staff had received appropriate training and there were good clinical protocols and improved service provision.'*

10.11 Elements of good practice were recognised:

> *'HP9 …….The segregation unit was clean and well ordered and record-keeping had improved. Segregation unit staff had received mental health*

awareness training and there were good links to the mental health in-reach team.'

'HP21 The Mental Health In-Reach Team provided a good service, but resources for primary mental healthcare were stretched and there was no day care facility. There were no delays in assessing prisoners and arranging transfers to hospital.'

'HP35 The counselling, assessment, referral, advice and through care service for drug users had significantly improved and group work, including the short duration programme, was now run. There continued to be good links with local drug intervention programmes. The drug strategy still covered the men's and women's prisons and needed to be disaggregated to reflect the specific needs of the different populations.'

10.12 In relation to specific health service issues which had been the subject of criticism, it was noted that in relation to previous recommendations, targets set by the Inspectors had been achieved:

'2.110 All prisoners should be assessed during reception or induction as to whether they have a physical, mental and/or sensory disability, or learning disabilities including dyslexia. ***Achieved.*** *Reception processes included questions on disability and other conditions, followed by a more detailed screening questionnaire completed by healthcare staff. The health and safety officer was notified by email.'*

'2.156 A protocol for joint working and dual-diagnosis should be developed between CARATs and the mental health in-reach team. ***Achieved.*** *A suitable protocol had been established and published. Staff reported a working knowledge of the protocol and records demonstrated adherence and successful joint working. A dedicated dual-diagnosis worker was part of the mental health in-reach team.'*

'2.161 All staff should have access to clinical supervision. ***Partially achieved.*** *Clinical supervision was being introduced for nursing staff, but dedicated supervisors had not yet been identified for the majority of healthcare staff. The clinical governance lead was a trained supervisor and nurses were encouraged to establish links with external supervisors. Protected time to undertake supervision was in place. The Mental Health In-Reach Team (MHIRT) had established clinical supervision within their specialty. We repeat the recommendation.'*

'2.164 Clinical records should be kept securely in accordance with data protection and the Caldicott principles. ***Achieved.*** *Clinical records were held securely in healthcare. A dedicated filing system appeared to be well managed and only health staff could access clinical records.*

Electronic records were maintained on SystmOne, which was password protected.'

'2.203 A formal arrangement for the provision of mental health out-of-hours support should be established. ***Achieved.*** *Any prisoner in crisis was referred to and seen by a member of the Mental Health In-Reach Teamand/or the GP. If the crisis could not be resolved, the community crisis intervention team was contacted for support. It had not yet been necessary to use this facility, which was testament to the mental health team's excellent management of prisoners.'*

10.13 However, a recommendation which related to the MHIRT had not been achieved:

'2.202 Health services should provide day care for men less able to cope with life on the wings because of mental health problems. ***Not achieved.*** *There was no day care for men less able to cope with life on the wings due to mental health problems. Primary mental health services delivered by prison staff were minimal, with only one registered mental nurse (RMN) carrying a caseload. However, this RMN had been allocated one day a week to work on mental health policies and develop the service. The RMN worked with the Mental Health In-Reach Team (MHIRT) and was developing a mental health screening tool for all prisoners arriving at Peterborough. Funding for psychological therapies was being sought and group work was underway. We repeat the recommendation.'*

10.14 Inspection Report July 2011

10.15 The Inspectors were pleased with the progress which they noted on this occasion. The following introductory comments were made in relation to the men's prison:

'The men's prison had improved since our last inspection and there were encouraging signs that it was on an upward trajectory.'

'….Health care services were good but there were problems with the appointment system, leading to a high rate of non-attendance at clinics.'

'HP9 There had been no self-inflicted deaths in the men's prison since it had opened. Good investigations took place into incidents of serious self-injury. It was not clear that learning points from these and other information obtained were always used to inform and develop practice. Assessment, care in custody and teamwork (ACCT) documents were generally of a high standard, with detailed initial assessments and good support from mental health nurses at reviews. Most care maps had clear targets and daily support records showed a good standard of care. Listeners felt well supported.'

'HP12 The integrated drug treatment system (IDTS) service was well established with good joint working between the clinical management

team and the counselling, assessment, referral, advice and through care (CARAT) service, except CARAT workers did not attend clinical reviews'.

'HP21 Perceptions of the quality of healthcare were still very poor, but the overall service had improved. A new management structure was working effectively and, while much remained to be done, particularly to develop work with the primary care trust, some progress had been made. A better healthcare applications system was needed to ensure quicker access to appointments. The Mental Health In-Reach Team provided a good service, but resources for primary mental healthcare were stretched and there was no day care facility. There were no delays in assessing prisoners and arranging transfers to hospital.'

'3.25 On average, 20 ACCT documents were opened each month and around 13 prisoners self harmed. Eight ACCT documents were open at the time of the inspection. ACCT documents were generally of a high standard and considerably better than in 2006. Assessments were detailed and most reviews included support from mental health nurses, although drugs workers and the family liaison officer had commented that they were rarely invited to reviews'.

'Substance use

2.146 Substance misuse nursing provision should be extended to reflect the demand and requirements of those subject to clinical support. ***Achieved.*** *One nurse with special interest in substance misuse delivered detoxification services. This nurse was supported by a healthcare assistant trained to Royal College of General Practitioners (RCGP) level 2. A further substance misuse nurse was being recruited to bring staff numbers to an adequate level.'*

'Health services

2.159 An urgent review of staffing levels and skill mix should be undertaken. ***Partially achieved****. Staffing levels and skill mix had been reviewed informally, but there was no documentary evidence to support this. A skills mix review was also underway. Additional qualified nurses and healthcare assistants had been recruited to improve overall numbers and the skill mix of health professionals. An improved grading structure provided better management of specialist areas and improved career progression for health professionals. Administrative support was inadequate, with simple tasks not completed because of pressure of work. Important issues were addressed appropriately and on time, but additional administrative support was needed if all administrative functions were to be completed in a timely manner.'*

'Section 5: Health services

5.1 Overall primary care services were good and the range was adequate for the needs of the population, with substantial improvements since 2006. Mental health services were good and primary mental health and in-reach services had recently integrated. Prisoners complained about delays in obtaining appointments to see a doctor or dentist but provision of services was good, with only short waiting lists. Some problems with the organisation of appointments were indicated by the high rate of non-attendance at some clinics. Health care facilities were good and the department was fully staffed, with a satisfactory skills mix. Nurses held lead speciality roles and there were good links with the wider prison.'

'General

5.2 …Working relationships between health care staff and other departments were good and those with NHS Cambridgeshire had improved.'

'Clinical governance

5.6 Clinical governance meetings were held quarterly and included key health care staff, primary care trust (PCT) representatives and corporate advisers. The meetings informed the partnership board and actions were addressed through the health delivery plan.'

'Mental health

5.42 The mental health in-reach services were based at the prison and included a team leader and three mental health nurses, one of whom was a learning disabilities nurse, a substance use specialist, an administrator and two part-time psychologists. Two primary care mental health nurses had recently been integrated with the team. The services had also contracted over seven clinical sessions from a psychiatrist, which was considered too many and was under review. The facilities were satisfactory and the total caseload for both men and women prisoners was 35, with an average of three new referrals a week. In 2010, a total of 78 men had been referred. The team had just had SystmOne installed and had yet to migrate records and manage future patients using the system. Following our last inspection and a recent inspection by the Care Quality Commission, the team had developed more robust mechanisms for reporting incidents to the PCT and revised information-sharing protocols.

5.43 Prisoners were generally positive about the quality of mental health care and the team had started an annual audit to survey patient experience and inform practice. The team had regular single point of contact meetings that were multidisciplinary and used to discuss current cases. There were good links with community teams. Some visiting counselling services were available. There were no day care services.

10.16 Key Points

1. HMP Peterborough has been the subject of a number of reports by HM Inspector of Prisons.
2. An inspection report prepared in October 2006 was highly critical of the provision of healthcare at the prison. Clinical governance at the prison was also criticised (see Paragraph 10.6).
3. In October 2008, HM Inspector of Prisons took the view that the MHIRT provided a good service but noted that resources were stretched. The MHIRT were noted to have established clinical supervision.
4. In July 2011, HM Inspector of Prisons remained of the view that the MHIRT provided a good service. Seven sessions were provided by a psychiatrist to support the MHIRT. This was considered excessive and was under review.
5. In July 2011, HM Inspector of Prisons noted that, following their last visit and a visit from the CQC, the MHIRT had developed more robust mechanisms for reporting incidents and had revised their information sharing systems. The Inspector also noted that the MHIRT had established an annual audit to establish the patient experience of the service.

11.0 INVESTIGATIONS INTO THE DECEASED'S DEATH

11.1 Investigation by the Prisons and Probation Ombudsman (the 'PPO').

11.2 The PPO investigates all deaths that occur among prisoners, whatever the cause of death.

11.3 The PPO carried out an investigation (the 'PPO Investigation') into the circumstances surrounding the Deceased's death in February 2011. The PPO Investigation was suspended pending the criminal investigation and proceedings. The PPO Investigation focused on events prior to the Deceased's death, and in particular, whether sufficient action had been taken in response to information suggesting that the Deceased might have been at risk from other prisoners.

11.4 The PPO Investigation found no evidence indicating that the Deceased, his friends, or prison staff realised that other prisoners were planning an assault. However, the PPO did take the view that there was evidence that the Deceased was alienating some of the other prisoners through his behaviour. This evidence was captured in security information reports, but little action had been taken to deal with what might be considered a 'pattern' of unacceptable behaviour.

11.5 The PPO Investigation made five recommendations. Two related to the way staff record and address inappropriate and potentially violent behaviour by prisoners. The third recommendation reminded staff to take account of security information when allocating prison jobs. Another recommendation concerned dealing with prisoners who might be involved in the buying and selling of goods. The final recommendation refers to the need to audit the cell alarm system. The PPO Investigation did not address any healthcare issues attaching to the Deceased, Mr A or Mr B.

11.6 Key Points

1. The Prison and Probation Ombudsman carried out an investigation into the circumstances surrounding the Deceased's death in February 2011.
2. The PPO found no evidence indicating that the Deceased, his friends or prison staff knew that an assault against the Deceased was planned by other prisoners.
3. The recommendations made by the PPO did not relate to any healthcare issues relating to Mr A or Mr B.

12.0 PRISON MHIR SERVICES

12.1 Compared with the general population, individuals who are the subject of custodial sentences have very high rates of mental health problems of all kinds. An estimated 10% of remanded men and 14% of all female prisoners have experienced a psychotic illness in the previous 12 months. Some 16% of all British prisoners have four or five co-existing mental health disorders. There are high rates of self-harm and suicide – it has been calculated that the risk of a prisoner committing suicide is seven times higher than for the general population.

12.2 Despite this, detection of mental illness on reception to prison has been found to be ineffective, with many prisoners' mental disorders left both undetected and untreated. The standard of prison healthcare has been of concern since the earliest reports on prison welfare, with frequent campaigns for the NHS to take responsibility for prison healthcare from the Home Office. A report entitled 'Patient or Prisoner', published in 1996, highlighted the shortcomings in the prison healthcare system at that time. It also argued for equivalence, namely that *'prisoners are entitled to the same level of healthcare as that provided in society at large'*.

12.3 In 2005, the Department of Health published a policy paper entitled 'Offender Mental Health Care Pathway' (Department of Health NIMHE 2005). The paper set out best practice templates to guide providers and commissioners of services for those involved in the criminal justice system.

12.4 A Home Office report 'A Five Year Strategy for Protecting the Public and Reducing Re-offending' (Home Office 2006) then followed. It placed emphases on protecting the public, punishment, reparation and rehabilitation. Following publication of this report, devolution of commissioning responsibilities for prison health care was completed in all prisons in 2006 and, as part of this, Mental Health In-Reach teams, based on the National Service Framework model of community mental health teams, were introduced into prisons.

12.5 The NHS is now responsible within the Prison Service for providing mental health care in prisons. MHIRTs are multiprofessional teams similar to community mental health teams which aim to offer prisoners the same kind of specialist care and treatment they would receive in the community. Prison MHIRTs were originally intended to be the main vehicle for improvements in mental health services for prisoners, especially those with 'severe and enduring mental illness'. National policy

has now been broadened to include all those in prison with any mental health problems.

12.6 MHIR Services have tended to develop using limited and idiosyncratic models of care. Official guidance on the development and operation of MHIR Services has deliberately been non-prescriptive, in order to allow services to develop which suit local circumstances and needs.

12.7 Constraints within the prison environment, such as security issues, information sharing, and treating prisoners without their consent have had an impact on the translation of community-based treatments into secure settings. Conflicting views on the balance between care and control within a prison environment have also affected the success of these treatment models in the prison environment. In addition, there are a number of additional hurdles for MHIRTs to establish an equivalent service.

12.8 Firstly, it can be difficult to identify severe mental illness, particularly where MHIRTs are reliant on prisoners' own reports at reception health screening. Secondly, it can be difficult to implement the Care Programme Approach (CPA) in secure settings. It is estimated that a quarter of MHIRT patients are not registered on the CPA, despite having severe and enduring mental health problems. Concerns have also been raised about how best to include prisoners' carers in the CPA process. Lastly, concerns about information sharing and confidentiality may also make effective implementation and co-ordination of the CPA problematic. Most of the clinical activity undertaken by MHIRTs is focused on assessment and liaison or support. There is very little face-to-face therapeutic activity.

12.9 In 2007, a number of key reports were published which highlighted the continuing challenges faced by MHIR Services. These reports included the following:

- 'Improving Health, Supporting Justice: A strategy for improving health and social care services for people subject to the criminal justice system' (Department of Health 2007)
- 'The Corston Report' (2007)
- 'Review of Women with Particular Vulnerabilities in the Criminal Justice System; HM Inspectorate of Prisons report' (2007)
- 'The Mental Health of Prisoners: A thematic review of the care and support of prisoners with mental health needs'
- 'Towards Effective Sentencing' (House of Commons Select Committee on Justice, 2008)

12.10 While all of these reports recognised that progress and improvements had been made, they were critical of the failure of MHIR Services to achieve 'diversion' and 'equivalence' for offenders. The primary concerns outlined in these reports included the fact that the funding and quality of mental health services in prisons was still well short of being 'equivalent' to those available in the community.

12.11 In July 2007, the Mental Health Act 2007 received royal assent. The new Act amended the Mental Health Act 1983. Whereas the 1983 Act contained distinct categories of mental disorder, including mental illness and psychopathic disorder, the 2007 Act replaced these categories with a single concept of 'mental disorder'. It also removed the requirement that, in order to treat a person with psychopathic disorder compulsorily, it had to be certified that medical treatment would alleviate or prevent deterioration in the patient's condition. Following introduction of the 2007 Act, in relation to any form of mental disorder, there is now a requirement only that, so far as treatment is concerned, 'appropriate treatment' be available. Previously, prisoners with personality disorders, who satisfied the definition of psychopathic disorder in the 1983 Act, were regarded as untreatable and were not assessed with a view to a hospital order or a transfer to hospital being made. Following introduction of the 2007 Act, there is now a lower threshold for entering treatment programmes and also the development of services for people with personality disorder, within the prison system and in the NHS outside prison. MHIRTs now have to play a part in the assessment of prisoners who would not previously have been referred to them.

12.12 In April 2009, the Bradley Report was published ('Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System'). This independent review was commissioned to examine the extent to which offenders with mental health problems or learning disabilities could, in appropriate cases, be diverted from prison to other services and considered the barriers to such diversion. The recommendations which were made included the organisation of effective liaison and diversion arrangements and the services needed to support them.

12.13 The Bradley Report sparked a review of Government strategy. The following recommendations from the Bradley Report cover areas related to MHIR provision for personality disorder and drug services:

- Improved services for prisoners who have a dual diagnosis of mental health and drug/alcohol problems should be urgently developed.
- Joint care planning between mental health services and drug and alcohol services should take place for prisoners on release.

12.14 Evidence in recent inspection reports at HMP Peterborough suggests that steps have already been taken to implement many of these recommendations. For example:

12.15 Inspection report Oct 2008 - Para HP35:

> *'The counselling, assessment, referral, advice and through care service for drug users had significantly improved and group work, including the short duration programme, was now run. There continued to be good links with local drug intervention programmes. The drug strategy still covered the men's and women's prisons and needed to be disaggregated to reflect the specific needs of the different populations.'*

12.16 Inspection report Oct 2008 - Para 2.156:

> *'A protocol for joint working and dual-diagnosis should be developed between CARATs and the mental health in-reach team.* ***Achieved.*** *A suitable protocol had been established and published. Staff reported a working knowledge of the protocol and records demonstrated adherence and successful joint working. A dedicated dual-diagnosis worker was part of the mental health in-reach team.'*

12.17 Inspection report July 2011 - Para HP12:

> *'The integrated drug treatment system (IDTS) service was well established with good joint working between the clinical management team and the counselling, assessment, referral, advice and through care (CARAT) service, except CARAT workers did not attend clinical reviews. A good range of interventions tackled a broad range of drug-related issues. Dual diagnosis provision was well integrated with community agencies. Although the positive mandatory drug test rate was just above target, there was effective and well-coordinated drug supply reduction practice.'*

12.18 Inspection report July 2011 - Para 2.146:

> *'Substance misuse nursing provision should be extended to reflect the demand and requirements of those subject to clinical support.* ***Achieved.*** *One nurse with special interest in substance misuse delivered detoxification services. This nurse was supported by a healthcare assistant trained to Royal College of General Practitioners (RCGP) level 2. A further substance misuse nurse was being recruited to bring staff numbers to an adequate level.'*

12.19 A further recommendation in the Bradley Report was as follows:

> *'An evaluation of the current prison health screen should be undertaken in order to improve the identification of mental health problems at reception into prison.'*

12.20 The Bradley Report also recommended that robust models of primary health services should be developed, ensuring an appropriately skilled workforce to assess and treat

those with mild to moderate conditions. HMP Peterborough has struggled to achieve this objective. Further, HM Inspector of Prisons' Report dated July 2011 suggests that staffing issues amongst the prison's primary healthcare services which are distinct from CPFT have contributed to a failure to achieve this recommendation:

> *'2.159: An urgent review of staffing levels and skill mix should be undertaken.* ***Partially achieved****. Staffing levels and skill mix had been reviewed informally, but there was no documentary evidence to support this. A skills mix review was also underway. Additional qualified nurses and healthcare assistants had been recruited to improve overall numbers and the skill mix of health professionals. An improved grading structure provided better management of specialist areas and improved career progression for health professionals. Administrative support was inadequate, with simple tasks not completed because of pressure of work. Important issues were addressed appropriately and on time, but additional administrative support was needed if all administrative functions were to be completed in a timely manner.'*

12.21 In relation to personality disorders, the Bradley Report stated:

> *'An evaluation of treatment options for prisoners with personality disorder should be conducted, including current therapeutic communities in the prison estate.*
>
> *An evaluation of the dangerous and severe personality disorder programme should be conducted to ensure that it is able to address the level of need.*
>
> *In conjunction with other government departments, the Department of Health, the National Offender Management Service and the NHS should develop an inter-departmental strategy for the management of all levels of personality disorder within both the health service and criminal justice system, covering the management of individuals with personality disorder into and through custody, and also their management in the community.'*

12.22 This recommendation has been achieved on a national basis via the consultation process on the Offender Personality Disorder Pathway Implementation Plan (Oct 2011) (DOH & MoJ). The Key Principles underpinning the strategy are as follows:

- The personality disordered offender population is a shared responsibility of NOMS (National Offender Management Service) and the NHS;
- Planning and delivery should be based on a whole systems pathway approach across the criminal justice system and the NHS recognising the various stages of an offender's journey, from conviction, sentence, and community based supervision and resettlement;

- Offenders with personality disorder who present a high risk of serious harm to others should primarily be managed through the criminal justice system with the lead role held by offender managers; and
- Treatment and management should be psychologically informed and led by psychologically trained staff; and focuses on relationships and the social context in which people live.

12.23 The Offender Personality Disorder Pathway is now in the process of being implemented throughout the country, including in HMP Peterborough. The target population for the pathway is individuals who are likely to have severe personality disorders and are assessed as presenting a high likelihood of violent or sexual offence repetition and a high or very high risk of serious harm to others. It is expected that there will be a clinically justifiable link between the personality disorder and the risk.

12.24 The Bradley Report also encouraged the Department of Health to examine the current role of MHIRTs and explore how they can be refocused on providing services for those with severe mental illness. This includes the development of liaison and diversion services to undertake some of the current non-clinical activities. In addition, NHS commissioners were urged to consider how to improve the provision of mental health primary care services in prison, including considering the involvement of non-health agencies, including statutory and third sector providers, in order to improve the support for prisoners with mental health problems or learning disabilities.

12.25 The Government responded to the Bradley Report with 'Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board' (2009) (the 'Plan'). This sets out a five year strategy for offender health based on the recommendations set out in the Bradley Report. The Plan sets out a specific timetable for addressing all of Bradley's recommendations, as well as delivery targets for women offenders, alcohol and drug problems and issues relating to physical health needs.

12.26 As part of the Independent Investigation, the MHIRT was asked whether HMP Peterborough or CPFT had a strategy regarding *'Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board'* (2009) in relation to its activities.

12.27 The Independent Investigation Team understand that CPFT were leading members of a Coordinating Forum in relation to the implementation of the Bradley reforms and

recommendations across Cambridge and Peterborough. This was a multi-agency group set up in 2011 which was tasked to *'look at the issues regarding the Bradley Report and how and what needs to be implemented within Cambridge and Peterborough.'*

12.28 Documentation which CPFT provided to the Independent Investigation Team identifies that the focus of the Coordinating Forum was on adults with mental health problems. A number of key issues were identified by the forum including:-

1. The fact that a number of initiatives were taking place but these were not linked together and were operating in isolation.
2. Difficulties in communication between the services involved with offenders with mental health issues. In particular, it was identified that information systems across the offender mental health pathway did not link up.

12.29 The Draft MHIRT Operational Policy states:

> *'This Policy reflects the government (Bradley Report 2009) and specialist services directorate objectives.'*

12.30 It is encouraging that the MHIRT has recognised the importance of the Bradley Report. However, the Independent Investigation Team note that in providing this information, the MHIRT did not reveal the overall strategic approach which motivated or drove these changes, the specific goals which were or remain to be delivered, or the extent of liaison between the various providers. In addition, the MHIRT did not provide any details as to the timetable for implementation of this strategy, nor indeed did it identify the processes by which the MHIRT could measure whether its overall strategic goals had been achieved.

12.31 It is relevant to note that an initiative such as that set out in the Bradley Report, requires cooperation from a number of agencies. CPFT have advised the Independent Investigation that:

> *'The prisons did not fully engage with the process which meant that the opportunities to make significant changes were limited. However, we accept that more could be done and will revisit as part of our action plan to implement the Independent Review revisit.'*

12.32 Key Points

1. MHIRTs are multidisciplinary teams similar to Community Mental Health Teams which aim to offer prisoners the same kind of specialist care and treatment which they would receive in the community.
2. A number of key reports have been published, the aims of which have been to highlight the challenges faced by MHIRTs in delivering a service that achieves equivalence for offenders.
3. In April 2009, a report entitled 'Review of People with Mental Health Problems or Learning Disabilities in the Criminal Justice System' (the Bradley Report) was published. This report made a series of recommendations in relation to provision of services for offenders who had a dual diagnosis of mental health and substance misuse problems.
4. The Bradley Report also made a series of recommendations in relation to the management of offenders with personality disorders.
5. A five year strategic plan relating to offender health, based upon the Bradley Report, was developed by the Government in 2009. This plan sets out specific timetables and delivery targets towards implementation of the recommendations made in the Bradley Report. The plan is contained in 'Improving Health, Supporting Justice: The National Delivery Plan of the Health and Criminal Justice Programme Board'.
6. It is clear that the Bradley Report has influenced delivery of care and service provision to offenders at HMP Peterborough. There is evidence in HM Inspector of Prison Reports that changes to services have been made following the Bradley Report. However, CPFT acknowledges that it could do more to implement the recommendations of the Bradley Report and have stated that they will revisit this and prepare an action plan.

13.0 PROFILE OF CAMBRIDGESHIRE AND PETERBOROUGH NHS FOUNDATION TRUST

13.1 CPFT was formed on 1 June 2008 under the Health and Social Care (Community Health and Standards) Act 2003, succeeding the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

13.2 CPFT provides mental health and specialist learning disability services for approximately 755,000 patients across Cambridgeshire and Peterborough and in some service areas beyond this geographical boundary. It also provides some specialist services on a regional and national basis.

13.3 CPFT has approximately 2,500 staff working across 75 sites in Cambridge, Huntingdon, Peterborough and Fenland. Its services include:

- Child and adolescent mental health services;
- Adult mental health services;
- Older people's mental health services;
- Forensic and specialist mental health services;
- Substance misuse services;
- Specialist learning disability services;
- Improving Access to Psychological Therapies;
- Liaison psychiatry and unexplained symptoms.

13.4 CPFT has for some time faced challenges in its delivery of care and has faced criticism about its performance from bodies such as the CQC, which regulates and inspects hospitals in England to ensure that government standards are met. The CQC is responsible for licensing all providers of health and social care. It has the power to close services down if they are below standard. The CQC assesses all registered health care providers against essential standards that are set out in regulations. Registration is based on a self-declaration of compliance. The standards focus on the outcomes of care achieved.

13.5 Care Quality Commission Concerns

13.6 CPFT is registered with the CQC and currently has no conditions on its registration. It is registered to carry out services at eight locations. However, on 5 January 2012, the CQC issued formal warnings to CPFT requiring it to do more to improve standards of care at the CPFT’s main site in Cambridge or face further regulatory action.

13.7 On 21 March 2012, the CQC published further reviews of compliance concerning the progress which CPFT made following the issuing of compliance warnings in January 2012.

13.8 CPFT has addressed the concerns raised by the CQC in January 2012 and is now compliant in care planning and the environment (namely providing safe and suitable premises) which were areas which the CQC identified as being of major concern. The Independent Investigation Team understand that during the course of a visit to CPFT in August 2012, the CQC found compliance in all seven areas which it inspected (respect, safety transfers between services, protection, sufficient staffing, notification of deaths and reporting of important events in people's lives).

13.9 External Governance Review

13.10 CPFT commissioned DAC Beachcroft in December 2011 to carry out a review of its leadership and board capabilities, together with a review of governance structures and processes.

13.11 DAC Beachcroft's report was highly critical of the Board of CPFT, noting that *'it has not been a unified, unitary or balanced Board'.* The report also highlighted the fact that *'the Board has failed to deliver effective oversight or challenge'.*

13.12 DAC Beachcroft's report highlighted several issues regarding Board leadership, capabilities, interactions and processes. CPFT accepted the report's findings and is currently implementing the recommendations made.

13.13 Changes in the Board of Directors

13.14 Three new executive directors have recently been appointed to the Board. These appointments are Medical Director, Chief Executive Officer ('CEO') and Director of Nursing. In addition, a Chief Information Officer and Director of Service Improvement joined the Trust in April 2012.

13.15 CPFT have also started the process to replace the existing Chair of the Board whose term of office was due to end on 30 November 2012. In addition, a further non-executive director will be appointed to the Board.

13.16 Actions taken to address concerns

13.17 On 5 December 2011 CPFT CEO 1, the newly appointed and current CEO of CPFT wrote to all staff in the following terms:

'As an organisation, we are not delivering care at a standard that we can be proud of. You will know that, in places, care has fallen below the standards all patients have a right to expect. Specifically, we have major issues in patient safety, delivering essential standards and basic care. These areas need significant and immediate improvement. We are currently the worst performing organisation in the East of England.

'In the last year our standards have dropped, we do not give people enough time and our surroundings are not good enough'.

13.18 CPFT CEO 1 subsequently initiated a series of actions to address concerns. The Board has also implemented additional changes including the following:

- Executive performance management has been strengthened;
- Quantitative measures have been put in place regarding Outcome standards and patient experience, whereas information reported previously was largely qualitative;
- New datasets and dashboards have been developed to illustrate performance and will be received by the relevant committees and Board; and
- Committee structures have been simplified by merging the Mental Health Act Committee with the Quality and Healthcare Governance Committee to ensure quality issues are captured and considered at a single committee.

13.19 MONITOR

13.20 MONITOR is the current regulator of NHS Foundation Trusts such as CPFT. It uses a risk-based system of regulation. MONITOR's Compliance Framework sets out how each NHS Foundation Trust's compliance with the terms of its authorisation is monitored. Its Quality Governance Framework measures the structures and processes in place to ensure trust-wide quality performance in line with MONITOR's requirements.

13.21 MONITOR publishes two risk ratings for each NHS Foundation Trust:

i. governance (rated red, amber-red, amber-green or green); and
ii. finance (rated 1-5, where 1 represents the highest risk and 5 the lowest).

13.22 MONITOR uses the term 'governance' to describe the effectiveness of an NHS Foundation Trust's leadership. Performance measures, such as whether foundation trusts are meeting national targets and standards, e.g. a reduction in MRSA rates, are utilised in this respect.

13.23 In 2011, MONITOR established compliance criteria for Boards. These require Boards to have regard to the Quality Governance Framework and demonstrate their compliance with the following:

1. Describe their own objectives for improving quality;
2. Identify metrics to monitor quality in terms of clinical outcomes, patient or service user safety and experience, and expected levels of performance;
3. Ensure they have in place systems, processes and procedures to monitor, audit and improve quality, including meeting their own objectives, health care targets and indicators and complying with all relevant legislation, and that relevant risks or shortfalls are identified, understood and mitigated;
4. Maintain effective governance systems to monitor and report on cleanliness, patient safety and experience in a timely fashion;
5. Consider serious incidents and patterns of complaints; and
6. Maintain a programme of internal audit review and independent assurance that supports the certification process.

13.24 When a Foundation Trust is at risk of breaching its terms of authorisation MONITOR requires that organisation to explain why and an action plan from the Board would normally be initiated. If this plan fails to demonstrate improvement within an acceptable time period, MONITOR's Board will consider using its formal powers to intervene.

13.25 Concerns highlighted by MONITOR about CPFT

13.26 On 21 March 2012, MONITOR found CPFT to be in significant breach of the terms of its authorisation due to its failure to provide effective leadership and governance.

13.27 The decision was triggered by the failure of the Trust Board to address concerns raised by the CQC within an appropriate period of time.

13.28 Following a period of review, MONITOR had found that the Board was failing to exercise appropriate non-executive leadership in identifying and addressing risks to quality of care. The regulator was concerned that, despite the fact that the Trust had dealt with concerns raised by the CQC in May 2010, it believed that there remained a risk that without effective Board oversight further issues may arise.

13.29 Stephen Hay, Chief Operating Officer at MONITOR, said:

'The central issue is that, while the Trust has now addressed the CQC's concerns, the way they did this and the time they took revealed a lack of strong leadership at Board level.

'We welcome the steps the incoming Chief Executive has already taken. However, if the Board cannot drive improvements in the way they run the Trust, there is a risk that similar issues may arise again.

'We will be keeping a close eye on the Trust and will review its progress against specific actions. We've made it clear that if the Trust fails to deliver timely and sustainable progress, we'll look again at whether we need to take further regulatory action.

'As CPFT is in significant breach of its Authorisation, it will continue to be red rated for governance risk.'

13.30 A key factor in MONITOR's decision was the fact that, in MONITOR's view, CPFT's governance systems had not identified the issues raised in CQC reviews. MONITOR took the view that whilst action had been taken to remedy the issues identified by the CQC, it was not yet clear whether changes made by CPFT were fully embedded or indeed were sustainable.

13.31 In addition, MONITOR took the view that CPFT does not currently have independent assurance that its quality governance systems are sufficiently robust to ensure that any future issues are picked up and dealt with in a timely manner. Significantly, MONITOR was also of the view that the CPFT Board was not able to articulate what good quality governance was. MONITOR took the view that this would improve once the proposed quality governance review had been completed and its resulting recommendations addressed. However, MONITOR was concerned that until those recommendations had been successfully implemented, the possibility of insufficient Board challenge and scrutiny arose. This gave rise to a further concern for MONITOR in that in its view, the Board does not currently have the capacity to identify and manage risks to service performance whilst remedial actions are being embedded.

13.32 Key Points

1. CPFT has been the subject of criticism from a number of regulatory bodies, including the CQC and MONITOR, in relation to the standard of care which it provides.

2. The Board of CPFT has been the subject of criticism by the CQC and MONITOR. The criticisms include poor leadership and a failure to deliver effective oversight or challenge. Poor governance structures and processes have also been identified.
3. In March 2012, MONITOR found CPFT to be in significant breach of its terms of authorisation as a result of its failure to provide effective leadership and governance. This decision was in part due to the CPFT's failure to address concerns raised by the CQC within an appropriate period of time.
4. A key factor which caused MONITOR concern was that CPFT's governance systems had not identified governance issues highlighted in CQC reviews.
5. In addition, MONITOR was also concerned that CPFT's current governance systems are not sufficiently robust to ensure that any future issues would be identified promptly.
6. Significant changes have been made to the Board of CPFT in an attempt to address these issues and a Governance Review is currently underway.

14.0 PRISON MHIR SERVICES AT HMP PETERBOROUGH

14.1 Service Provision

14.2 The MHIR Service was established at the newly opened HMP Peterborough in 2004/5. The objectives of the MHIR Service at HMP Peterborough are set out in an operational policy dated September 2005 (the 'Operational Policy'). The original objectives of the service were stated to be:

> *'2.1 To establish a process for addressing the needs of prisoners with severe and enduring Mental Illness within the integrated Care Programme Approach in prisons.*
>
> *2.2 To improve transfers between Prisons and NHS, Primary Healthcare Teams, Community Mental Health Teams, Inpatient Services - local, Regional Secure Units, special hospitals and Independent sector.*
>
> *2.3 To provide a service which is equally accessible to all users, which will address their individual needs in a non-judgemental and non-discriminatory manner.*
>
> *2.4 To provide advice on the management of mental health problems by other professionals - in particular advice to the prisons' primary Healthcare staff.'*

14.3 The Operational Policy goes on to state that 'Priority will be given to prisoners who are assessed as being eligible for CPA. Prisoners falling below the eligibility standard will remain the responsibility of the Primary Healthcare Team.'

14.4 The Operational Policy states that the eligibility criteria for the service were as follows:

'5.1 The service will prioritise those prisoners who:

- *Meet the criteria for CPA.*
- *Have a severe and enduring mental illness and require care and treatment whilst in custody.*
- *Are currently under the care of, or who have recently disengaged from their local Mental Health Team.*
- *Have a dual diagnosis where the primary diagnosis is a major mental illness.*
- *Have a depressive or anxiety related illness that has not responded to treatment by the primary care team (Prison Healthcare Centre).*
- *Have a personality disorder and present with: severely impaired functioning and/or significant risk of self-harm.'*

14.5 One of the purposes of a document such as an operational policy is to help team members and individuals outside the immediate team, whose work brings them into contact with the service, understand the interaction of roles and responsibilities within the service. It also plays a central role in allowing those outside the MHIRT to understand its processes, including eligibility criteria, referral processes, governance structures, procedures and indeed its direction.

14.6 The Operational Policy had not been updated or reviewed at the time of the Independent Investigation despite stating that it was due for review in September 2006. This is a matter of concern given the changes in operational practices over a significant period of time, including the changes made by CPFT to implement the plan set out in *'Improving Health, Supporting Justice; the National Plan of the Health and Criminal Justice Board'* referred to in Paragraph 12.26 above.

14.7 The Independent Investigation Team asked the current Team Leader of the MHIRT during the course of the Investigation about the status of the Operational Policy:

> *'JH: ...your Operational Policy, is this the current one, September 2005?*
> *Team Leader 1: No, it's, it's in the process, in fact we had a meeting today, we're in the process of changing it coz it's completely out of date, our services have changed quite drastically, whereas that doesn't talk about primary it doesn't talk about IAPT, it doesn't talk about we're now a 7 day service. So we are reviewing it and pretty much you know re-writing it.'*

14.8 The MHIRT have now completed the process of reviewing the Operational Policy. A comprehensive draft (the 'Draft Operational Policy') has been produced and is awaiting ratification by the Board of CPFT. Members of the MHIRT had an opportunity to contribute to the development of the new operational policy through the MHIR Governance forum. The Independent Investigation Team have been advised that the MHIRT are already following the Draft Operational Policy in relation to its day to day activities.

14.9 The Independent Investigation Team note that the aims of the MHIRT as set out in the Draft Operational Policy include the following:

> *'to treat prisoners with mental health problems where current good practice and research evidence indicates that mental health intervention will prove beneficial and create a positive health outcome.'*

14.10 The referral process adopted by the MHIRT and set out in the Draft Operational Policy is now as follows:

‘6.1 Referrals can be made by any member of staff working with a prisoner.

6.2 Referrals should be made to the Prison Healthcare Centre in the first instance in order that they carry out an initial primary care mental health screening. The only exceptions to this will be prisoners being received with CPA packages (either from community services or other Prison In-Reach Teams). These referrals should be passed directly to the In-Reach Service.

14.11 In relation to secondary mental health, the Draft Operational Policy now makes it clear that:

‘Referrals to the secondary care Mental Health In Reach Services may also include prisoners who meet at least one of the following criteria:

- *Prisoners for who their diagnosis or problem are not yet clear and require further assessment*
- *Prisoners with a dual diagnosis whose primary diagnosis is a major mental illness*
- *Prisoners with a diagnosis of personality disorder who present with severely impaired functioning and/or significant risk of self-harm.’*

14.12 The Independent Investigation Team welcome the introduction of an updated operational policy.

14.13 Service Level Agreement (‘SLA’)

14.14 At the time of the Deceased’s death, a robust SLA which identified the core services and objectives to be delivered by the MHIRT at HMP Peterborough was not in place. When the MHIR Team Leader was asked what the remit of the MHIRT was in 2008, her answer was clear. It was stated:

‘…our remit was from the PCT service level agreement was to look after people with severe enduring mental illness.’

14.15 This statement conflicts with the eligibility criteria set out in the Operational Policy adopted by the MHIRT in 2005.

14.16 Director of Adult Specialist Services 1, the Director responsible for the MHIRT at the time of the Deceased’s death, was asked to identify the policies and plans which were put in place by CPFT to enable those who were working at ground level in providing care to decide how to allocate resources in order to meet the eligibility criteria. Her response was as follows:

'….The prison was a newly built, newly opened one, and the prison In-Reach team joined it at the point of opening, so there was I think a huge process of evolving and learning together, that went on. And I think at a simple level there was an attempt to prioritise around the clinical need that was perceived at that point. And I think what the In-Reach Review explains, and it comes over very clearly, is that the priorities were just not very clear….'

14.17 During the course of the Independent Investigation, it became clear that members of the MHIRT did not apply the eligibility criteria set out in the Operational Policy in 2008. Instead the MHIRT believed the eligibility criteria for access to the MHIR Service to be *'severe enduring mental health problems'*. Given the resourcing issues identified at Paragraph 10.9, this may have been an appropriate allocation. However, it was not one which had been formalised nor did it appear to have received Board scrutiny.

14.18 Quality of Service

14.19 Performance indicators are a necessary constituent of measuring the quality of the service which is provided and are an integral part of a SLA. The MHIRT was not the subject of formal performance indicators under which it had to provide information to CPFT, or indeed any other body, at the time of the Deceased's death. The Team Leader at the time of the incident was asked about performance indicators in interview. Her response was as follows:

'JH: …what kind of performance data were you generating then?

Team Leader 2:
Just its paper.

JH: Paper.

Team Leader 2:
What we suddenly realised was that if someone was to walk in and say what do you do we had no evidence of what we did do apart from if you went through every file and referrals.

JH: Right.

Team Leader 2:
So what we did was it was just a very simple form that says people seen, telephone calls, CPA document or anything just a list of things. We try to look at, what are everyone on, the data outside and try sort of emulate that really.

JH: And when did that come about?

Team Leader 2:
That sort of came about in 2007.'

14.20 Further,

'JH: …..you having to generate any external reports say for the Prison Governor for the Health Care Director – anything like that?

Team Leader 2:
For the Partnership Board we just had to share our figures and people we'd seen.

JH: And that would be a Word, effectively a Word document with referrals?

Team Leader 2:
Yeah.

JH: Referrals.

Team Leader 2:
Yeah I mean it wasn't that sophisticated, it was just basically erm we would tweak things since. It was just basically just so you know who we'd seen how many people we would seeing, any DNA's, staffing, stuff like that.'

14.21 In the absence of proper management information generated by the MHIRT, it is difficult to understand how decisions were taken concerning service delivery and direction, both by the Board of CPFT and indeed its commissioners, in order to meet the needs of the prison population at this time.

14.22 The Independent Investigation Team understands that Needs Assessments were undertaken in an attempt to establish the number of people within the prison with mental health needs and what proportion of those people had unmet needs. The Needs Assessments were based upon questionnaires completed by prisoners. Such questionnaires place the patient experience at the heart of the service planning process, which is an element of good practice. It also allows the service to understand from a patient's point of view the areas in which it is performing well and also how the service might be improved. Such exercises are valuable tools in assessing performance from the patient perspective. However, they should not be used as a performance indicator in isolation and also they must be performed at regular and defined intervals.

14.23 In addition, the lack of a robust SLA, performance indicators, and the poor level of information regarding the case load of the MHIRT would have denied the Board of CPFT an opportunity to provide scrutiny and leadership to the service. This is a particular concern given that the MHIRT was a relatively new service being run by individuals who did not have previous experience of a prison environment. In addition, the service itself was not connected to CPFT's computer systems and was not part of its clinical governance framework, which restricted the flow of management information, as is discussed in the following paragraphs.

14.24 Governance of the MHIRT

14.25 Clinical governance is an umbrella term that covers activities that help sustain and improve high standards of patient care. It ensures that healthcare providers can be held accountable for continuously improving the quality of their services. Clinical governance is at the heart of patient safety.

14.26 During the course of the Independent Investigation it became clear that, prior to 2008, clinical governance systems and processes were not well established within the MHIRT.

14.27 The Independent Investigation Team was impressed by and grateful for the candour of members of the MHIRT in discussing the lack of governance arrangements operated by the MHIRT in 2008. The position was summarised in interview in the following terms:

'JH: …so the key plank effectively of your clinical governance system was the operational policy?

Team Leader 2:
Yeah.

JH: And you sat down and wrote that in 2005?

Team Leader 2:
5 [2005].

JH: OK, how did you take it out from there in terms of things like risk management and, clinical governance itself? How did you formulate that?

Team Leader 2:
We didn't have really any governance.

JH: Right.

Team Leader 2:
Not because we didn't want to.

JH: No, no.

Team Leader 2:
It's all very nice to have guidelines, and we know about our accountability and duty of care, but there was no, robust structures in place and theirs didn't come about until 2008. If I'm honest, they didn't come about until 2008 when I think we all sat down and thought we're tired of this and this is what we need and then we got a dedicated management structure in place. Then we got the supervision policy. There was lots of policies come in but we could then say this is what we need.

JH: So that was in 2008?

Team Leader 2:
Yeah.

JH: Was that after Mr A?

Team Leader 2:
Yes.

JH: It was after Mr A.

Team Leader 2:
But it wasn't about Mr A, because we lost somebody in 2007 at another prison, and it was then we started to look at our systems as well…'

14.28 The MHIR Team Leader was also asked during the course of her interview about the depth of clinical governance training which she had undergone in order to perform her role in establishing and running the MHIRT. She responded to the question as follows:

'JH: Have you been in any courses on clinical governance?

Team Leader 2:
I've done the e-learning on governance and I've done it in my management training.

JH: Right.

Team Leader 2:
Erm, but we've got erm, a dedicated governance team.

JH: Right. And do they come in to see you?

Team Leader 2:
We invite them to our development sessions.'

14.29 In considering the issue of clinical governance in 2008 within the MHIRT, it is necessary to put the approach adopted by the MHIRT into the context of what was happening in the broader prison environment where it provided its service. It is clear that clinical governance issues were not restricted to the MHIRT. For example, an HM Inspector of Prisons Report in relation to HMP Peterborough dated October 2006 stated, *'One of our main concerns was the provision of healthcare, which was among the worst we have seen for some considerable time'.* In addition, clinical governance arrangements were noted to be 'limited'. The defects were considered so serious that HMP Inspector of Prisons requested meetings with senior managers from the prison and NHS in order that remedial action be taken.

14.30 In 2005, when the MHIRT was established, the service was a new one. Team members were new to the prison environment and had limited managerial experience. This was not an uncommon scenario at the time. However, the MHIRT at HMP Peterborough faced a number of additional difficulties. In particular, the MHIRT did not have access to CPFT's computer systems. This had a considerable impact on the information flow into and out of the MHIRT. This situation was allowed to continue for a considerable period of time.

14.31 During the course of the interviews, the Independent Investigation Team was advised that prior to 2008, policies and procedures were circulated to the MHIRT in paper form. Management information was also provided in paper format. The lack of an effective computer link also impacted upon the flow of patient information. Effectively, a situation had been created where the MHIRT was isolated from CPFT and was deprived of the benefit and support of its clinical governance structure and patient data base.

14.32 During the course of her interview the Team Leader at the time of the Deceased's death summed up how she tried to deal with this situation.

'Team Leader 2:
You know I was busy concentrating on ok being a Team Leader but I was a clinician you know and I was busy trying to make, trying to do

what I could to keep people safe but also recognising that we were so stretched that, that's not an uncommon factor with In-Reach teams I'm not sitting here, I'm not of the can't do attitude I'm more what can we do.

JH: Yes.

Team Leader 2:
Within the resources that we have.'

14.33 The Independent Investigation Team understands that MHIRTs often face practical difficulties due to a lack of financial resources. This is not a problem which is unique to HMP Peterborough and its MHIRT. However, the Independent Investigation Team is concerned that for a period in excess of three years prior to the death of the Deceased the Board of CPFT did not take action to offset the practical difficulties caused by a lack of computer link in order to satisfy itself that the MHIRT had an appropriate level of clinical governance in place and, effectively, left the MHIRT to develop key clinical governance systems in isolation. This leaves clinical staff unsupported and impacts adversely upon the quality of care afforded to patients.

14.34 The lack of information provided to CPFT concerning the activities of the MHIRT should have flagged a potential problem. The absence of this information should have been detected through CPFT's control systems and in fact raises concerns about the overall quality of CPFT's control systems at the time. The Independent Investigation Team note the conclusions of MONITOR referred to at Paragraph 13.31 in this regard.

14.35 The Independent Investigation Team believes that it is the responsibility of the Board to ensure that its teams of professionals are properly supported in all their activities as part of its overarching duty to ensure patient safety. This did not happen in relation to the establishment of the MHIRT at HMP Peterborough, whose professionals were denied the support of an effective clinical governance regime.

14.36 During the course of interviews held with former directors of CPFT, Director of Adult Specialist Services 1 was asked about problems within the clinical governance structure operated by CPFT. She confirmed that she was aware that there were problems, even before the Service Review of the Prison In Reach Mental Health Team (the 'Review') took place (see Paragraph 24.1). She also explained her response to the problem in the following terms:

'JH: … did that come as a surprise to you that the, that there were issues?

Director of Adult Specialist Services 1:

No, no because we'd been having that conversation. I'd been and had a series of meetings about what we could do and I think my feeling at the time was that when you've got a whole range of different issues being raised.

JH: Yes.

Director of Adult Specialist Services 1:

At one point you're saying OK well that would be the priority we'll try and sort that out and then it seemed to shift to other issues. And so it seemed helpful to take a step back and have someone independently look at the whole thing, and I suppose help us make recommendations.'

14.37 This response is unsatisfactory at a number of levels. CPFT did undertake a number of initiatives which were intended to strengthen the operation of the MHIRT. For example, management capacity was increased. CPFT services were restructured in 2007 and resources shifted to MHIRT to create a full time team manager post working across the three prisons, and focusing a senior manager role on Specialist Services to include MHIRT, to increase the senior management capacity. The senior manager maintained specialist services directorate meetings with managers and senior clinicians to both deal with service issues and link with ongoing Trust issues. These meetings included clinical governance matters.

14.38 In addition, there were several initiatives to support the three MHIRTs working more closely together, including team development days, sharing practice and linking to trust-wide events, e.g. 'learning the lessons', trust mental health leadership team. A main initiative was developing and adapting the Trust CPA process for the prison environment. This work was developed in 2008 and a working version was finalised in March 2009. The risk assessment component of CPA was audited. CPA was focused upon as a central process in the safe delivery of care.

14.39 Whilst these initiatives were of benefit to the operation of the MHIRT, the Independent Investigation Team could not detect a strategic overarching approach to tackling the issues which the MHIRT presented at that time nor indeed the issues which arose from Mr A's care.

14.40 A Review was carried out in April 2009. The Independent Investigation Team regards this as an element of good practice. The Review is dealt with more fully at Section 26. The Independent Investigation Team, however, did not see any evidence of an interim plan being put in place to address clinical governance issues arising from the

MHIRT prior to completion of the Review and implementation of its recommendations taking place. This is a matter for concern as it potentially places patient safety at risk. It also presents a potential leadership issue at Board or senior management level.

14.41 Case Load

14.42 The case load of the MHIRT has changed significantly during the period between 2005 and 2011. The table below sets out the number of referrals during this period:

YEAR	TOTAL MALE	TOTAL FEMALE
2005	65	74
2006	285	332
2007	227	257
2008	141	165
2009	46	96
2010	78	62
2011	107	80

14.43 The above table shows a sharp decline in the number of cases being referred to the MHIRT when compared to the number of referrals in 2007. However, in 2011 the MHIR Service assumed responsibility for primary mental health services in addition to secondary mental health services. The Team is currently handling approximately 187 cases as a result.

14.44 The Independent Investigation Team was advised during the course of the Independent Investigation that case loads are currently being revised. There is currently no average number of cases for each member of the MHIRT or any guidelines which dictate the number of cases that any individual might have.

14.45 Staffing Levels

14.46 Initially when the MHIRT was established in 2005, it comprised the following:

Team Leader 1.0 WTE (Whole Time Equivalent)

Nurse Practitioner 1.0 WTE

Nurse Practitioner on secondment 1.0 WTE

Psychiatrist	0.2 WTE
Total	**3.2 WTE**

14.47 When Mr A was receiving care from the MHIRT in September 2008, the staffing levels had risen and were as follows:

Team Leader	1.0 WTE
Psychiatrist	0.4 WTE
Mental Health Nurse	1.0 WTE
Nurse	1.0 WTE
Psychologist	0.6 WTE
Assistant Psychologist	0.4 WTE
Substance Misuse Practitioner	0.6 WTE
Team Administrator	1.0 WTE
Total	**6.0 WTE**

14.48 In a report produced by The Royal College of Psychiatrists London entitled 'Prison Psychiatry: Adult Prisons in England and Wales' (CR141) (February 2007), advice on psychiatric staffing in prisons was given in the following terms:

'Box 1 Provisional guidance for consultant norms and appointments

*CATEGORY **B** LOCAL REMAND PRISON OF **500** PLACES*
- *0.5 wte consultant (general adult or forensic)*
- *0.5 wte. non-consultant grade*
- *Plus 0.2 wte addiction specialist sessions and psychotherapy input as recommended below.'*

*CATEGORY **B** DISPERSAL PRISON of **500** PLACES*
- *0.5 wte (forensic or forensic rehabilitation)*
- *0.5 non-consultant grade and psychotherapy input as recommended below.'*

14.49 The Sainsbury Centre for Mental Health advised in 2007 the following resources in respect of a Category B prison for 550 prisoners:

*'**CMHT staff***	***WTE***

Consultant psychiatrist	*0.5*
Consultant psychotherapist	*0.3*
Staff grade doctor	*0.5*
Clinical psychologist	*0.5*
CPNs (including 1 LD trained)*	*3*
OT	*1*
OT helpers	*2*
Technical instructors	*1.2*
Social worker or probation officer	*0.5*
Counsellor	*0.5*
Creative therapist	*0.5*
Speech and language therapist	*0.5*
Total	***11.0***

Substance misuse team staff	***WTE***
Addiction specialist	*0.2*
CPNs	*3*
Total	***3.2***

** LD = learning disability'*

14.50 This suggests that the MHIRT did not comply with the National Guidance relating to staffing levels in 2008. However, this lack of compliance is replicated throughout many prisons throughout the UK as they seek to achieve equivalence with NHS provision in the community. Indeed, staff resourcing issues are also an issue in community services.

14.51 Clinical Leadership in MHIR Service

14.52 At the time of Mr A's care, the MHIR Service had available to it the services of a consultant psychiatrist who was able to devote the equivalent of 0.4 WTE sessions to the MHIR Service at HMP Peterborough. The manner in which this was organised ensured the presence of a consultant psychiatrist at HMP Peterborough on three days each week.

14.53 This individual reported to the Clinical Director and was accountable to the Medical Director for professional matters. The main duties of this post included:

*'**Clinical***
Provide a consultant clinical service and clinical leadership within the Prison Inreach Service.

Work with inreach service and other colleagues to ensure that effective clinical care is maintained across the prison inreach services.

*‘**Administration***
Maintain appropriate administration systems.

Contribute to data collection systems providing performance management data and commissioning data.

Participate in clinical audit.’

*‘**Management***
Work with the operational manager and contribute to the development and management of the inreach services.

Contribute to the planning and development of prison inreach mental health services.’

*‘**Leadership***
Provide clinical leadership to the mental health inreach service.’

14.54 The current provision for a psychiatrist in the MHIRT appears to be unclear which could potentially deny the MHIRT of clinical leadership. This issue is dealt with more fully at Paragraph 24.23 onwards.

14.55 Team Leadership

14.56 In its early stages, the MHIRT experienced difficulties in recruiting individuals with appropriate experience. This was a problem shared across many MHIRTs at the time. Team members were recruited from a number of different sources. None had previous experience of prison healthcare. However, Team Leader 2, the MHIRT Team Leader at the time of the Deceased’s death, had previously worked within the criminal justice system in Court Diversion for approximately five years. Team Leader 2 originally qualified as a State Enrolled nurse in 1982 before qualifying as a State Registered Nurse in 1994. She had previous management experience having been a ward manager of a 30-bed acute in-patient unit. She was responsible for establishing the MHIRT when the prison opened.

14.57 During the course of her interview, Team Leader 2 was asked about the training which she had received in order to establish a multidisciplinary team. Her response was that she had had no specific training but relied on their previous management experience as a ward manager. She also pointed out that at the time that the MHIRT was established there were limited training courses concerning mental health in-reach.

14.58 Team leadership of the MHIRT has remained stable in that the original Team Leader is now Team Manager of Community Justice Services, which is the service to which the MHIRT reports. This is a recent appointment. However, it is clear that overall management of the MHIRT outside membership of the actual team has been the subject of significant changes, with a number of line managers being in post for short periods or management posts being unfilled due to retirement or sickness issues. It also meant that posts which were filled were often done so on a temporary or seconded basis.

14.59 Whilst management at Board level remained constant until early 2012, the MHIRT was subjected to significant change at the Senior Manager and Team Manager levels. During the course of 2008, for example, the Senior Manager position was held by three different individuals. In addition, during the course of the Independent Investigation, it became clear that none of the managers responsible for overseeing the work of the MHIRT had previous experience of offender healthcare.

14.60 Team Meetings

14.61 At the time of the Deceased's death, the MHIRT had a weekly meeting which was held on a Tuesday and was attended by team members at that time. This meeting allowed multidisciplinary consideration of cases. Minutes of those meetings were kept and indeed there is some evidence of their circulation to the Team Manager at that time. The existence of such meetings is an element of good practice.

14.62 Supervision

14.63 Supervision is a fundamental component of good governance and quality assurance. However, supervision was not a feature of the MHIRT governance structure in 2008. The Team Leader, when asked how supervision was managed responded in the following terms: *'I think it was more about opportunity, it wasn't formalised'*.

14.64 In fact, the Operational Policy dated 2005 and which was still in force during the Independent Investigation states:

'12.0 Supervision

12.1 All members of the In-Reach Service are responsible for arranging appropriate professional/clinical supervision according to their individual needs (as established through PDP review process).

12.2 The In-Reach Service will provide clinical supervision to mental health staff within the Prisons Health Care Teams in order to facilitate the management of cases by the primary care team and add to the

effectiveness of the primary mental health screening (NIMHE 'Offender mental health Care Pathway' 2005).'

14.65 CPFT implemented a policy entitled 'Clinical Management and Supervision' in December 2008. It states that:

'All line managers have a responsibility to ensure that supervision is in place for all staff according to the standards set out in this policy. All employees have a responsibility to participate constructively in supervision.

The Trust considers Supervision as necessary in order to:
- *Support staff to work in an effective way*
- *Support development of knowledge and insight*
- *Ensure staff are managed and developed,*
- *Ensure services are delivered competently and effectively,*
- *Ensures a focus on and an achievement of organisational goals*
- *Assures service users, their carers and the organisation that the department is accountable for local core practice standards and nationally set standards.'*

14.66 Crucially, the Operational Policy states '*Effective supervision is essential to good organisational governance'*.

14.67 As part of the Review, an audit was commissioned by CPFT, the aim of which was to '*establish whether members of the In-Reach service are receiving supervision, both management and clinical, according to the standards outlined in the CPFT Supervision Policy (February 2009)*'. Additionally, the Review sought to gain additional information about how well current supervision arrangements met perceived needs. A Report summarising the findings of the Review was produced on 4 August 2009. The Review concluded that:

'there was evidence that some standards for clinical supervision of in-reach staff are being adhered to; whereas in other areas there are gaps or uncertainties about meeting CPFT standards.'

'Clinical supervision arrangements (according to the feedback received from supervisors and supervisees) appear robust for psychologists and the psychotherapist. Some of the nursing staff reported gaps in the provision of clinical supervision. Of most concern was the lack of provision for some team leaders, and one member of staff had not received a formal appraisal of their clinical practice for four years. Whilst staff members who were consulted for the purpose of this report were understandably cautious in their comments about their colleagues, team dynamics and personalities and the differing disciplinary perspectives are important factors to consider with regards to clinical supervision.'

14.68 During the course of the Independent Investigation, the Independent Investigation Team was pleased to note that supervision had a much greater profile in the MHIRT than at the time of the Deceased's death. Substance Misuse Practitioner 1 in particular stated that she now received a greater level of supervision which she felt was of great benefit to her. However, the supervision arrangements in the MHIRT still face difficulties due to unavailability of staff. If staffing levels are not sufficiently high, there is a risk that service demands will result in the supervisor or supervisee being unavailable for supervision. In addition, it is not always easy to identify appropriate supervisors. The Independent Investigation Team understand that CPFT have now introduced a Trust wide 'Supervision Policy and Procedure – Managerial and Clinical Supervision' in June 2012. This policy which is currently in operation with the MHIRT specifies that staff must undergo a minimum number of supervision sessions per year. Guidance is also given in the policy as to who is responsible for conducting supervision. The policy is audited through the annual appraisal system.

14.69 Key Points

1. MHIRT had an Operational Policy in place which was drafted in September 2005. This policy had not been formally reviewed at the time of the Independent Investigation despite significant changes to the practices and procedures operated by the MHIRT. This is a matter for concern. However, the MHIRT now has an updated Draft Operational Policy which is comprehensive and does take into account the current practices and procedures operated by the MHIRT.
2. The eligibility criteria for inclusion in the service in 2008 included:
   'Have a dual diagnosis where primary diagnosis is a major mental health illness'
   'Have a personality disorder and present with severely impaired functioning and/or significant risk of self harm'.
3. In 2008, eligibility criteria applied in practice by MHIRT members did not accord with the eligibility criteria set out in the Operational Policy.
4. The Board of CPFT did not provide clear guidance to members of the MHIRT as to how resources should be allocated in relation to the eligibility criteria set out in the Operational Policy.
5. The Board of CPFT were not in a position to monitor the nature or quality of the service provided by the MHIRT due to an absence of performance indicators and proper management information.
6. The MHIRT did not fall within the clinical governance arrangements relating to CPFT in 2008 and the staff of the MHIRT were not provided with support to develop such

systems internally. Accordingly, the Board of CPFT could not provide effective scrutiny of or leadership to the MHIRT.

7. The MHIRT was not linked to CPFT's computer systems in 2008. This had a significant impact upon the flow of information into and out of the MHIRT. This had a direct impact upon the quality of clinical governance and as a result patient care.
8. Despite being aware of a number of issues concerning the clinical governance structures within the MHIRT, the Board of CPFT did not take action to address these concerns until April 2009. When it did so it instigated an external review. This is an element of good practice. However, the Independent Investigation Team is concerned about the lack of interim support which was provided to the MHIRT prior to the conclusion of the external Review.
9. The MHIRT case load reached a peak in 2007-8. The case load is currently declining.
10. The MHIRT did not comply with national guidance relating to psychiatric staffing levels in 2008.
11. The MHIRT management team did not have direct experience of offender health care when it was established in 2005. The MHIRT was subjected to significant changes in management during 2008.
12. The MHIRT had regular team meetings in 2008, which is an element of good practice.
13. There was no formal supervision structure in place in the MHIRT in 2008. A structure is now in existence, which indicates learning.

14.70 Additional Learning

A number of potential learning points arise from the issues identified in this section.

1. Throughout the course of the Independent Investigation, the Independent Investigation Team was hampered by the lack of formalised documentation evidencing systemic and procedural changes which have been made by the MHIRT. An example of this is the failure of the MHIRT to put in place a comprehensive Operational Policy which reflected the processes and procedures operated by the MHIRT between 2005 and 2012.
2. A significant feature of the governance culture operated by the MHIRT in 2008 was its lack of formality. Without procedures and processes being documented, it becomes very difficult to assess the strengths of a governance system. The Independent Investigation Team believes that this lack of formality is an active and on-going risk to the clinical governance framework operated by the MHIRT.

3. The Independent Investigation Team is concerned about the speed of CPFT's response to clinical governance issues, as demonstrated by its delay in conducting a follow up service review (more fully discussed in Paragraph 24.6). The Independent Investigation Team note, however, that during the course of the last 12 months, steps have been taken to improve the links which the MHIRT has with the CPFT clinical governance framework. In addition, the CPFT clinical governance framework itself has been strengthened with a new Trust Operating Model which enhances capacity to oversee clinical effectiveness by the creation of a new Director of Nursing post who is supported by a dedicated team. However, on-going work is necessary to ensure that CPFT policies are tailored by the MHIRT to suit the needs of its service, for example, in relation to CPA processes.

15.0 MR A'S PREVIOUS CONTACT WITH MENTAL HEALTH SERVICES

15.1 Mr A's history demonstrated a significant degree of previous contact with mental health services from a relatively early age. These contacts are set out below.

Date	Event
29 August 1991	Mr A's GP made a referral to Consultant Psychiatrist 1 in the following terms: *'Had a 'phone call from Mr A's mother and she was desperate for help with her middle son. Apparently he is basically getting out of her control. I understand there are three children, S aged 6, Mr A aged 8 and L aged 10. Mr A's mother however is quite concerned that her husband is not involved and that he should not know of the referral'*
26 September 1991	Letter sent to Mr A's mother via Healthcare Visitor in order to avoid Mr A's father becoming aware of it, offering an appointment to see Dr P at the Family Consultation Service.
16 October 1991	Appointment date at Family Consultation Service.
29 October 1991	Mr A's GP advised that Mr A and his family had not attended the appointment which had been made for them. A follow up appointment was not offered.
6 October 2003	Mr A stabbed himself deliberately. Absconded from surgical ward. Staff raised concerns about his mental health and noted that he had expressed suicidal ideas. Court Diversion service involved (Team Leader 2*[1]). Psychiatric assessment requested.
8 October 2003	Mr A unwilling to undergo psychiatric assessment. It is recorded in Mr A's notes that; '*Consultant advised Mr A stay on the ward for the next 2 days for further assessment of MH [Mental Health]. If he try to abscond then the surgical staff should place Mr A on S(2) MHA (1993)[sic]'*
9 October 2003	Mr A discharged himself from hospital. Mental Health Act assessment not undertaken. GP, Court Diversion and Probation Officer informed. Recommendation that Probation Service seek a referral for Mr A.
29 June 2006	Mr A's GP referred Mr A to Community Drugs Team in Peterborough in following terms: *'I shall be most grateful if you would kindly see this 23 year old*

[1] Subsequently became MHIR Team Leader

	unemployed patient of my partner who came to see me in the emergency surgery on Friday evening at 6.30pm expecting me to prescribe him some form of 'drugs'. *…. it appears that he has been using heroin in the past three months ago, given to him by his friends and he is using roughly about six bags a week, mostly as recreational use. He also smokes well over 60 cigarettes a day and continues to drink three to six units a day and about six litres of strong cider in a week.* *His past history includes trying drugs way back in 1998 and he gives a history of psychiatric disorder and as he is a new patient we are not sure of the details.* *He has a supportive family and his main aim is to come off using heroin; according to him he has never injected any form of drugs. As it was an emergency surgery I suggested that he came down to see me to discuss various other aspects of his vaccinations, immunisation and health screenings etc, but he has not managed to turn up.* *At the time of discussion he was very amicable and wanting to be seen by the CDT [Community Drugs Team] to get on to the methadone maintenance programme so that he could give up the use of the heroin and also wants to take care and control of his supportive family.'*
7 July 2006	Mr A was first assessed for treatment by PNDip [Peterborough & Neme Drug Intervention Project]. At that time he had been using heroin for 5 months and was considered to be a moderate user as he was smoking rather than injecting heroin. At this time he was using up to 0.8 g of heroin a day which cost between £40 and £50. Mr A was also using crack cocaine occasionally and was taking benzodiazepine tablets and alcohol. In the Pro-Forma Lifestyle Assessment his past use of antidepressants was noted. He was also stated to be sleeping 3 hours a night and that his partner and child had left him.
11 July 2006	Mr A seen by doctor. Mr A reporting heroin, crack cocaine and benzodiazepine use. Tested positive for heroin and benzodiazepines. Commenced methadone treatment.
20 July 2006	Mr A reviewed at Nene Drug Intervention Project. He stated that the methadone was making him drowsy and that he had used one bag of heroin in the last week. He was noted as still having problems with anger and requiring a referral for CBT [Cognitive Behaviour Therapy]. His methadone prescription was reduced from 60mls to 50mls at Mr A's request.

5 August 2006	Mr A was noted to be seeing a psychiatrist later that week.
9 August 2006	Letter – Community Drug Team to Mr A's GP in following terms: '*Thank you for your referral of this gentleman whom I was able to assess on the 25 July 2006. However, following contact from the Nene/DIP, I have been informed that Mr A referred himself to their Service and is now being prescribed a Methadone regime as of this date. I will, therefore, not open his file to the Community Drug Team but will allow the Nene Project to manage his treatment'.*
10 August 2006	Clinical review. Mr A tested positive for heroin and methadone. Mr A was noted to be *'worried about his anger and taking it out on family, Unable to identify triggers. Last used a week ago. Sleeping better. No concerns with physical and mental health. Plan To refer to M for Anger Management.*'
4 September 2006	Report from PNDip for the Child Protection Case Conference. It notes that Mr A did not engage fully with PNDip, missed several review appointments and failed to collect his prescription of methadone on a number of occasions. By 31 August 2006, Mr A had been in treatment for approximately 9 weeks. During that time he had missed two review appointments and had missed collecting his methadone on 3 occasions (which amounted to 14 days). During this period he tested positive for a number of substances including heroin, methadone and crack cocaine. Whilst Mr A had been able during this time to reduce his heroin use significantly, it was felt that he would benefit more from the treatment by improving his level of commitment in relation to attending appointments and picking up his script more regularly.
19 September 2006	Mr A scheduled for assessment at the Gloucester Centre by Consultant Psychiatrist 4. The retained copy of the letter to Mr A has been marked 'DNA' [Did Not Attend].
5 October 2006	Mr A remanded in custody at HMP Peterborough. Care transferred to CARAT team.
10 November 2006	A child protection conference was convened in relation to 3 of Mr A's children with whom he and his partner lived. The following information is contained in the minutes of that meeting: *'24 March 2006 – Mr A had stabbed himself on the top of his head by using a knife. During this incident, the Police were called and CS spray was used by them to gain control of the situation. The children were in the house at this time.'* The Chairperson of the meeting expressed concerns about Mr A's

	mental health. The conclusion reached by those attending the conference was that the three children with whom Mr A and his partner were living with at the time, should be placed on the Child Protection Register under the category of 'physical and emotional abuse'. The conference noted: *'The identified risks of significant harm to the children are:* *Physical – Child A sustained a bite mark believed to have been caused by an adult. Until that is resolved, he and the other children remain at risk of significant harm.* *Emotional – the children are living in turbulent home conditions where domestic violence is a feature and there are reports of Mr A self harming. This is likely to impact upon the children's emotional development …'* Mr A was subsequently convicted of biting child A.
20 June 2007	Upon release from custody Mr A was noted to be using heroin on a daily basis (0.2 bags). He resumed treatment under a Drug Rehabilitation Order with PNDip.
2 July 2007	Consultant Psychiatrist 4 wrote to Mr A's GP in the following terms: '*I saw Mr A at the request of the Peterborough Magistrates Court in October 2006 to prepare a Court Report for him for a pending appearance.* *I received a phone call from his Probation Officer, NB this morning. I understand that the case has now been dealt with and he was given a probation sentence.* *My recommendations to the Court if he was given a community order were that he should have psychiatric follow up for the following reasons:* • *Psychological help for his anxiety* • *Help with his alcohol use* • *Prescription of an antidepressant with anxiolytic properties to help with his anxiety* • *Attendance at day centre, e.g. Mosaic Centre for group work for self esteem* • *Possibly attendance at Learn Direct or other resources to help build his confidence and bring structure to his day.* *Mr A is not eligible for the Learning Disability Services as he has only reading and writing difficulties, rather than a learning disability. I would be grateful if you could refer him to the Adult Mental Health Services so that a referral to the Mosaic Centre can be made, he*

	can receive psychology input for his anxiety and help with his alcohol use.'
3 July 2007	Mr A given prescription for Subutex tablets.
10 July 2007	Mr A was seen as part of his ongoing drug therapy. At this time he was taking Subutex 6 mg daily and also was smoking heroin on alternate days. Mr A was not taking any other drugs or using alcohol at this time. Mr A noted to be experiencing: '*Anger management problems – to discuss with the key worker'* He was subsequently referred to a 'therapist'.
18 July 2007	A parenting and risk assessment was completed as a result of concerns which Peterborough City Council Services Children's Services had about Mr A's suitability to be an adult around children. A Child in Need Service Plan was completed. This stated: '*There was also discussion about who would be responsible for effecting the recommendations which were made by the psychiatrist, regarding Mr A's needs for monitoring. Mr A had whilst in prison requested for a referral to be made for him regarding his needs for bereavement counselling, as Mr A is still being affected by the circumstances surrounding his father's death. Mr A has in the past stated that he would benefit from counselling as it has been a trigger for him.* *The meeting was also informed that Mr A had been asking for counselling even prior to his release, however he has not been able to access any such service during the period of imprisonment.* *The meeting was also informed that the psychiatrist was going to write and instruct the GP involved with Mr A, to arrange the follow ups regarding counselling. The GP would then write to Mr A to attend an appointment; however this letter has not been received yet…* *There was also discussion regarding concerns which had been forwarded by the Community Drugs Team regarding information that there was a bit of raised voices when N (Mr A's Partner) and Mr A, and that staff in the team were concerned as they felt the incident bordered on the edges of violence towards N.'*
27 July 2007	Mr A reported sleep problems and his mood was described as 'labile'.

15.2 Key Points

1. Mr A's history demonstrated a significant degree of previous contact with mental health services from a relatively early age.

16.0 MR A'S OFFENDING HISTORY

16.1 Mr A had an extensive forensic history prior to his conviction for manslaughter on 22 December 2009. This history is not recorded in the records maintained by the MHIRT.

16.2 Mr A's first conviction was 9 March 1998 when he was 15. His convictions include two racially aggravated offences in 1999 and 2004. By 26 February 2004, he had been convicted of the following:

- 5 offences against the person.
- 1 offence against property.
- 17 theft and related offences.
- 3 public order offences.
- 7 offences relating to police, courts and prisons.
- 11 miscellaneous offences.

16.3 Mr A continued to offend and by May 2007 the Independent Investigation Team understands that he had been convicted on 19 occasions with 72 offences recorded against him. These included a number of violent assaults. For example, one conviction related to a child who Mr A bit and another to a serious assault on an individual using a soft drink can.

16.4 Mr A has received a variety of sentences including a number of custodial sentences. Following conviction for an offence of robbery in 2007, Mr A received a two year probation order which included the monitoring of his mental health and use of illicit substances. He was also electronically 'tagged' for 6 months. However, it appears that he broke the terms of his probation and was sent to HMP Peterborough where he stayed until the attack on the Deceased on 11 September 2008.

16.5 In passing sentence upon Mr A in respect of the manslaughter of the Deceased, the Judge made the following comments in respect of Mr A's history of violent offending:

> *'It starts with a common assault in 1998. In 1999, you punched a civilian detention officer. In 2000, you punched a man, cutting his eyebrow. In 2001, you struck a police officer by opening a car door. In 2002, you tried to rob a man by punching him in the face on a footpath. In 2004, you were one of a group who assaulted a householder who remonstrated with you about your behaviour in the street. In 2007, you committed more robberies, poking a victim in the eye and stamping on his stomach on the floor, taking his mobile phone and similarly, stamping on a second man -- sorry, punching a further victim to the chest in a separate incident.*

'… I have before me a psychiatric report … It charts a disturbing childhood history, during which you ultimately became involved in numerous fights, leading to your expulsion from school. Since then, your behavioural problems have continued. There is even mention of you committing violence whilst on a tag.'

16.6 Key Points

1. Mr A had an extensive offending history prior to him coming into contact with the MHIRT at HMP Peterborough. He had been convicted of a substantial number of offences including violent assaults.
2. Mr A had been given a range of sentences including a number of custodial sentences.

17.0 PSYCHIATRIC AND PRE-SENTENCE REPORTS

17.1 As a result of his contact with the Criminal Justice system, Mr A was the subject of a number of psychiatric reports in the period leading up to his conviction for manslaughter in December 2010. Extracts from these reports are set out below.

17.2 Report by Consultant Psychiatrist 2 dated 9 August, 2001

17.3 It appears that the referral to Consultant Psychiatrist 2 was as a result of a request made by Peterborough Social Services Department (North West Anglia Healthcare Trust) to the Court Diversion Service. The referral form, which is dated 15 June 2001 states:

> *'**INITIAL OUTCOME:** Crown Court 18/06/01*
>
> *Space of 2 ½ years this young man has committed offences x 6 convictions – he has been seen by 2 psychiatrist whilst in young offenders prison who identified this young man to have a major depressive order.*
> *1997 father committed suicide - ?? whether mother or brother had stabbed him not proven, since this Mr A has been committing crimes and spent the duration in Glen Parva.*
>
> ***FINAL OUTCOME: (if known)** → suggested that Mr A be further assessed and a report to be done by Consultant Psychiatrist 2.*
>
> *(well known to Group & D [xxx] says he's very childish, [xxx].'*

The Referral Form is unsigned.

17.4 Consultant Psychiatrist 2's views of Mr A, who was eighteen years old at the time, were as follows:

- *'Multiple specific learning disabilities (reading, writing, maths);*
- *Probable borderline generalized learning disability;*
- *Alcoholism (alcohol misuse, in remission primarily because he is in a controlled environment);*
- *Unresolved psychological issues surrounding the death of his father by suicide in 1998;*
- *Despite his offence history, Mr A did not suffer from antisocial personality disorder (sociopathy) or its adolescent precursor, conduct disorder.'*

17.5 In relation to instances of self-harm Consultant Psychiatrist 2 noted that:

'Mr A tried to hang himself after his father's death but was unable to make use of counselling offered at that time'.

17.6 By the time Mr A was eighteen he had developed an alcohol problem. Consultant Psychiatrist 2 described this in the following terms:

'He slowly increased his alcohol use and began experiencing violent outbursts when drunk, alcoholic blackouts and increasingly self-destructive criminal acts. Neither he nor his mother is aware of any organised post-incarceration or probation led care packages…..'

17.7 Consultant Psychiatrist 2's examination showed the following:

'He showed no evidence of hallucinations or delusions or other signs of psychosis. He was neither clinically anxious nor depressed. He was intellectually impaired, with a paucity of information and basic knowledge…'

17.8 Consultant Psychiatrist 2 took the view that Mr A required the following package of care and services:

'If he is incarcerated, it should be in a facility for young offenders, not an adult prison, and it should be a facility where the package can be begun (as below). Most importantly, there most [sic] be a continuing program following incarceration. Mr A's mother told me tonight that he had been 'in and out of secure units' but that ***there was never any follow-up*** *[emphasis in original].*

The package must begin with educational testing to determine his needs and abilities.

He must then be given remedial education in reading and maths. Without these he will never be able to obtain work in accord with his abilities and interests.

Next. he must be involved with organizations such as QEST through which job training and placement can be arranged. Mr A, as can be seen from his automobile related offences and their relationship in turn with his deceased father (who was a mechanic and with whom Mr A had positive experiences in auto mechanics in between his fathers imprisonments and alcoholic rages).

Simultaneously with the above, he must enrol with and stay with the Community Alcohol Team which is, at present virtually the only place he can get some personal counselling and which is necessary to keep his drinking under control. Should it be deemed that he needs adjunctive medication, either the Alcohol Team Consultant (as yet unknown) or myself (who is the consultant psychiatrist attached to the GP caring for Mr A and his family) would advise and supervise this portion of the care.

Lastly, if and when it becomes available, a short-term focused course of counselling to deal with his delayed grief and conflicts arising out of his father's suicide can be offered.

Failure to provide a program of this type and scope will result in his continuing to spiral out of control, graduate to adult facilities and become permanently lost.'

17.9 Consultant Psychiatrist 2 concluded by saying:

'...I have endeavoured to propose a potentially helpful program none of which is new, exotic, costly or unexpected. It all should have been instituted long ago. Whether or not he is incarcerated, any plan not providing these elements and planned follow-up is doomed to failure'.

17.10 Following Mr A's referral to Consultant Psychiatrist 2, Peterborough Social Services Department made a further referral to the Court Diversion Service on 23 August 2001. The Referral Form contains the following information:

*'**PRESENTING FACTORS THAT REQUIRE REFERRAL:** Asked for me to do an assessment due to him being seen by psychiatrist for a report & the fact Consultant Psychiatrist 2 had highlighted he (Mr A) had lots of problems Due in Crown x 3 weeks.*

IF KNOWN TO PSYCHIATRIC SERVICES: (details)
No'

17.11 A copy of Consultant Psychiatrist 2's report was provided to the Court Diversion Service. The response of the Court Diversion Service was as follows:

*'**INITIAL OUTCOME**: Poor eye contact, clearly doesn't want to be at the hostel Wants to be at home & see his friends. Can't sleep, spoke about his father who stabbed himself & that life went down hill with him offending.*
States he is ok apart from when he consumes alcohol he gets aggressive, cannabis calms him.'

***FINAL OUTCOME: (if known)** high risk of breaching his curfew as he is resistive to be being there and doesn't appreciate or respect regulations this may due to his immaturity*
no mental health problems evident or self harm issues'

The Court Diversion Form was signed by Team Leader 2, who would later have an involvement with the MHIRT and would again fail to take action recommended in a psychiatric report compiled in relation to Mr A's care.

17.12 Report Prepared by Consultant Psychiatrist 3 Dated 26th February 2004

17.13 Consultant Psychiatrist 3 recorded Mr A's past psychiatric history as follows:

'He believes that he saw a counsellor as a child, following the death of his father. During his last imprisonment at HMYOI Glen Parva, he saw a prison psychiatrist, who prescribed him anti-depressants, which he took for 3 months. However, with the exception of improving his sleep, he noticed no difference. Prior to this imprisonment and following self inflicted injuries, he saw a GP who gave him anti-depressants and referred him to the local psychiatric unit in Peterborough.'

In relation to alcohol and illicit substance intake, Consultant Psychiatrist 3 noted:

'Mr A admitted to drinking an excessive amount of alcohol prior to the alleged index offence. He claims to have drunk on average, 2 bottles of wine and 3 cans of beer at least twice per week, mostly at weekends. However, he told me that on the night of the alleged index offence he had not drunk much. He used to smoke Cannabis on a regular basis (around 1/4 ounce) between the age of 16 and 19. He denied consuming illicit substances during the night of the alleged index offence'.

17.14 Psychiatric Symptomatology was noted by Consultant Psychiatrist 3 to be as follows:

'Mr A admitted to feeling low in mood and being aggressive on many occasions, He admitted to on many occasions experiencing self referential ideation, being suspicious and getting paranoid about people and thinking that they were talking about him. This often made him have aggressive/homicidal thoughts. He also admitted to hearing occasional voices calling out his name. However, he denied having third person auditory hallucinations or hearing running commentary. He also denied thought insertion, withdrawal, broadcasting and blocking. Furthermore, he denied experiencing passivity phenomena.

He admitted to having low self esteem, but denied having lack of energy, inability to experience pleasure or problems with his appetite or weight. Nor did he experience significant sleep problems.

He admitted to variation in his mood, being impulsive, having carried out acts of self harm (he has scars on his left forearm, abdomen and scalp). Furthermore, he admitted to having a constant fear of being abandoned and having difficulty with relationships.'

17.15 Consultant Psychiatrist 3 concluded:

'He presents with a number of difficulties that relate to his personality, psychological well being and psychiatric symptoms. Clearly the untimely death of his father when he was 14 years old and with whom he had a close relationship and indeed tended to idolize was a major event in his life. If the

history that he has presented to me is correct, then it does appear that there has been a marked change in his life, since the death of his father. Although, he told me that he did receive counselling following the dramatic death of his father, the evidence suggests that this made little difference.

He presents with many features of Emotionally Unstable Personality Disorder, Borderline Type (F60.31, ICD10). The features that make up this disorder are described under the heading of psychiatric symptomatology. However, it should be noted that before one can confidently say that an individual suffers from a particular personality disorder, an independent collateral history needs to be obtained from someone who has a lengthy and in-depth knowledge of the individual.

Mr A also presents with psychotic symptoms, namely paranoia and possibly auditory hallucinations. However, at the present time, despite having a family history of paranoid schizophrenia, he does not fulfil the criteria to be given a diagnosis of schizophrenia. Clearly with his family history (his father apparently suffered from paranoid schizophrenia), he remains vulnerable. In addition, his use of Cannabis prior to imprisonment, further poses an increased risk of the development of significant psychotic disorder such as schizophrenia.

At the current time, I do not believe he requires admission to a psychiatric unit. If indeed the court convicts him of the charges and whether he is given a custodial or non-custodial sentence, I would like to respectfully recommend that he be given further psychological and psychiatric input. With regards to the psychiatric input, he may be helped with a small dose of anti-psychotic medication along with a 'mood stabiliser. He would of course require regular reviews by a Psychiatrist if he were to commence on the above medication.'

17.16 Pre-Sentence Report dated 20 Jul 2006

17.17 A Pre-Sentence Report prepared in advance of a hearing dated 29 June 2006 by Offender Manager 1, an Offender Manager with the Probation Service, describes Mr A as a 'persistent offender who presents as a high risk of re-offending'.

17.18 The Pre-Sentence Report sets out details of the offence which Mr A had been charged with on that occasion as follows:

'2.1 The defendant has a long history of self harm. On the evening of the offence he tells me that he was feeling particularly paranoid and uncomfortable and as a consequence he had cut his own head which was bleeding profusely.

2.2 He and his partner consequently attended the Accident and Emergency department and the local district hospital, but the defendant says that he found the nurse on the counter to be abrupt and unhelpful thus exacerbating his general feelings of paranoia.

2.3 He subsequently shouted obscenities at the nurse and says that he took a step towards her but had no intention of hitting her.

2.4 The defendant then left the hospital without receiving treatment. On the way home he noticed that a woman was looking out of the window, again, feeling paranoid and wondering why the person was looking at him the defendant put his head through her window causing it to break.

2.5 On their arrival home his partner telephoned for an ambulance, but Mr A refused to get in, later the police used CS gas upon him and he was eventually taken to hospital and was treated by having 18 stitches in his head.'

2.6. 'The Defendant has a history of committing offences whilst under the influence of alcohol and these matters are no exception. I understand from him that he had consumed a cocktail of spirits and was also under the influence of heroin.'

17.19 The Pre-Sentence Report goes on to state:

'3.4 A psychiatric report compiled in 1999 describes Mr A as suffering from 'a major depressive disorder characterised by depressed mood, irritability and withdrawal from usual interests'. Dr N linked the depression to the death of his father. Dr N recommended that he should have 'continuing psychiatric care' and concluded that a 'well thought through care plan for rehabilitation is essential'.

3.5 Mr A clearly struggles with feelings of anger relating to past events and consequently continues to have angry outbursts, which to the outsider would appear to be for no reason.'

17.20 In relation to Mr A's history of alcohol abuse:

'3.6 Probation records indicate that alcohol has been a constant factor in Mr A's offending and has clearly used alcohol to 'self medicate' in an effort to irradiate[sic] feelings of paranoia and depression. In March 2006 he also started to use heroin, but has already contacted the Nene Project and with their help has stopped using. He tells me that his alcohol use has also been dramatically reduced and he is currently drinking in the region of 2/3 pints of beer per week.'

17.21 The Pre-Sentence Report concluded:

'4.3 It is my assessment, however, that given Mr A's record of previous offences without the appropriate intervention he could still pose a risk both to himself and the public.

4.4 Mr A has not resolved his feelings towards the death of his Father and as a result continues to self-harm. His injuries from this are often of a serious nature, the most recent relates to the current offences where cuts to his head required 18 stitches.

4.6 There are areas, listed below, which are a cause of concern in the context of harm to the offender him/herself.

- *Risk of self harm'*

'5 Conclusion

5.3 It is clear that Mr A has deeply entrenched emotional difficulties as a result of his father's suicide. In my view he is likely to continue to offend if these are not sufficiently addressed. Whilst Mr A has had psychiatric reports, I believe the last one being in 2003 and psychiatric intervention this appears to be limited.

5.4 In my view if Mr A is to achieve long term change he requires specialist intervention.'

17.22 Report Prepared by Consultant Psychiatrist 4 dated 29 September 2006

17.23 Consultant Psychiatrist 4 had access to the following documents when he conducted a review of Mr A:

- Pre-Sentence Report from Offender Manager 1, Offender Manager dated 20 July 2006,
- Psychiatric Report from Consultant Psychiatrist 2 dated 9 August 2001,
- Letter from Mr A's GP to Consultant Psychiatrist 1 at Peterborough District Hospital dated 29 August 1991.

17.24 Consultant Psychiatrist 4 stated his understanding of Mr A's relationships with drug and alcohol use in the report:

'He said that he started to use alcohol when he was 13 years old. His drinking got worse when he was about 14-15 years old. At the worst he used to drink around 3 litres of 15% wine per day, and in the last 2 years he had started to cut back, but has really reduced in the last 10 months. He mentioned that he would get quite agitated if he was not able to get a drink and most of his drinking was taking place at his friends house, on the street and described various memory blackouts because of the excessive drinking.

He has been using heroin recently. He smokes it. He is currently under the care of the Community Drug Team. There have been times when he has not picked up his medication and used heroin instead but he is now trying hard to re-engage with services.'

17.25 Consultant Psychiatrist 4 noted the following features which are relevant to Mr A's forensic history:

> *'He was arrested for the first time just after the death of his father for shop lifting. He said that he has been arrested and served a prison sentence for numerous offences since then'.*

17.26 Consultant Psychiatrist 4 noted that Mr A was taking some steps towards addressing his anger issues:

> *'More recently he has started to attend the Nene Project for anger management and mentioned that that has helped him in the 6 weeks that he has attended. He described almost a constant state of anger'.*

17.27 In relation to psychiatric intervention, Consultant Psychiatrist 4 noted:

> *'I believe he saw a Psychiatrist between 2000 and 2002 in prison where he was prescribed mood stabiliser and antipsychotic medication which he took for 4 months and since leaving prison he has not been on these again. He is not currently on any other medication.'*

17.28 Consultant Psychiatrist 4 noted that, while Mr A described some anxiety related symptoms and had previously described paranoid thoughts, there was no other evidence to suggest that Mr A suffered from a psychiatric illness. Consultant Psychiatrist 4 concluded that Mr A's difficult behaviour was present before the death of his father. Following his father's death his offending became more or less continuous and there seems to be a relationship between his offending and his alcohol intake. Consultant Psychiatrist 4 noted that Mr A had started to smoke heroin and that he had some reading and writing difficulties.

17.29 Consultant Psychiatrist 4 made a number of recommendations about Mr A's future care. He was of the view that Mr A's ongoing management in relation to his anxiety disorder could be achieved through his GP without the need for referral to specialist psychiatric services. However, Consultant Psychiatrist 4 also stated that Mr A's risk increased significantly when he was intoxicated with alcohol. In addition, he made it clear that '*If the Court decides to give him a custodial sentence then he will be able to get appropriate help from the Health wing within the prison*.'

17.30 Consultant Psychiatrist 4 subsequently wrote to Dr M, Mr A's GP, on 2 July 2007. This letter stated:

> *'I saw Mr A at the request of the Peterborough Magistrates Court in October 2006 to prepare a Court Report for him for a pending appearance.*

I received a phone call from his Probation Officer, Probation Officer 1 this morning. I understand that the case has now been dealt with and he was given a probation sentence.

My recommendations to the Court if he was given a community order were that he should have psychiatric follow up for the following reasons:

- *Psychological help for his anxiety*
- *Help with his alcohol use*
- *Prescription of an antidepressant with anxiolytic properties to help with his anxiety*
- *Attendance at day centre, e.g. Mosaic Centre for group work for self esteem*
- *Possibly attendance at Learn Direct or other resources to help build his confidence and bring structure to his day.*

Mr A is not eligible for the Learning Disability Services as he has only reading and writing difficulties, rather than a learning disability. I would be grateful if you could refer him to the Adult mental Health Services so that a referral to the Mosaic Centre can be made, he can receive psychology input for his anxiety and help with his alcohol use.'

17.31 Consultant Psychiatrist 3 Report Dated: 18 February 2010

17.32 Consultant Psychiatrist 3 had assessed Mr A on two previous occasions, on 19 February 2004 and on 14 May 2007.

17.33 Consultant Psychiatrist 3 recorded some further details about Mr A's family history. It was noted that Mr A was the father of three children from two different partners. It was noted that, apart from his father suffering from paranoid schizophrenia, he has a younger sister who has diagnosis of borderline personality disorder and possibly bipolar affective disorder. He has an older brother who reportedly does not suffer from any psychiatric disorders.

17.34 Consultant Psychiatrist 3 noted that Mr A began smoking cannabis around the age of 16 years but gave up around 4-5 years ago as he felt it made him more paranoid. On the other hand, he had continued with misuse of heroin and substitute Subutex (buprenorphine primarily used to treat heroin addiction). He had been able to obtain both heroin and Subutex fairly regularly despite being in prison.

17.35 Consultant Psychiatrist 3 remained of the view that Mr A satisfied the diagnostic criteria for emotionally unstable personality disorder, borderline type (F60.31, ICD 10, 1992). In Consultant Psychiatrist 3's view, Mr A continued to describe pervasive

features of this diagnosis which included the volatility of his mood, impulsiveness, repeated acts of self-harm, fearing abandonment in relationships and indeed difficulties in forming relationships. Mr A also described being chronically bored and having episodes of psychotic symptoms which appeared to worsen with the misuse of cannabis.

17.36 Consultant Psychiatrist 3 also believed that Mr A was now exhibiting symptoms which would satisfy the diagnostic criteria for dependence syndrome for heroin (F1x.2, ICD10, 1992). These included his seeking behaviour for heroin/Subutex which appeared to take priority over other activities, his compulsion to take heroin/Subutex, his increased tolerance to their effects and withdrawal symptoms which were relieved by taking of heroin/Subutex.

17.37 Consultant Psychiatrist 3 considered whether Mr A was suffering from serious psychotic illness such as schizophrenia. Consultant Psychiatrist 3's view was that there was not enough objective evidence for such a diagnosis.

17.38 Consultant Psychiatrist 3 was of the view that significant traumatic issues from Mr A's early childhood, particularly the death of his father, had contributed to his continuous internal anger and presentation of emotionally unstable personality disorder. Consultant Psychiatrist 3 noted that Mr A had not had a formalised psychological assessment with appropriate psychological therapy in order to deal with these issues despite his previous recommendation that this should happen.

17.39 Consultant Psychiatrist 3 was also of the view that Mr A's dependence on heroin/Subutex required further evaluation and a detoxification regime instigated. Consultant Psychiatrist 3 was also of the view that Mr A would benefit from continuous psychiatric input with use of antidepressants along with mood stabilisers and small dose antipsychotics.

17.40 Key Points

1. Mr A had been the subject of a number of psychiatric reports prior to him coming into contact with the MHIRT at HMP Peterborough.
2. In 2001, a report was produced by Consultant Psychiatrist 2. This report identified multiple learning difficulties, alcoholism, and unresolved psychological issues relating to the death of Mr A's father. It was not felt that Mr A suffered from an antisocial personality disorder or its adolescent precursor, conduct disorder. Consultant Psychiatrist 2 recommended a detailed package of care for Mr A.

3. A report was produced dated 26 February 2004 by Consultant Psychiatrist 3. This stated that Mr A presented with many features of emotionally unstable personality disorder, but that a confident diagnosis could not be made at that stage. The report noted that Mr A presented with psychotic symptoms and that, while he was not suffering from a psychotic illness at that time, he posed an increased risk of such an illness developing. The report refers to the impact which the death of his father had on Mr A and that counselling had not resolved these issues. The report recommended further psychiatric and psychological input, including regular contact with a psychiatrist alongside treatment with antipsychotic and mood stabilising medication.
4. Consultant Psychiatrist 3's report dated 26 February 2004 was forwarded to the MHIRT in November 2007 by Mr A's solicitors. Mr A's solicitors noted that the Judge in sentencing Mr A in 2007 had instructed that Consultant Psychiatrist 3's report be passed to HMP Peterborough to be taken into account in Mr A's future treatment.
5. A review of Mr A was carried out in September 2006 on behalf of the Probation Service. The report noted that Mr A had previously described anxiety related symptoms and paranoid thoughts, but that there was no other evidence to suggest a psychiatric illness. It was noted that Mr A had started to smoke heroin and that there was a link between his offending and alcohol intake.
6. Consultant Psychiatrist 4 made a number of detailed recommendations for Mr A's future care which were subsequently brought to the attention of Mr A's GP on 2 July 2007. These recommendations included the following:

   'Psychological help for his anxiety

   Help with his alcohol use

   Prescription of an antidepressant with anxiolytic properties to help with his anxiety

   Attendance at day centre, e.g. Mosaic Centre for group work for self esteem

   Possibly attendance at Learn Direct or other resources to help build his confidence and bring structure to his day.'
7. A further psychiatric report was produced by Consultant Psychiatrist 3 on 18 February 2010. He concluded that Mr A met the diagnostic criteria for borderline personality disorder and dependence syndrome, and that there was insufficient objective evidence to diagnose a serious psychotic illness.

17.41 Additional Learning

1. Mr A was, like many individuals with multiple convictions, the subject of a number of psychiatric reports, some of which recommended a treatment plan. It is disappointing

that on two separate occasions recommendations in these reports have been disregarded by individuals working within the criminal justice system.

2. The Independent Investigation Team is of the view that the MHIRT may wish to consider the vehicles through which it could access reports of this nature in order to better understand the needs of its patients and any risks which they might pose.

18.0 DIAGNOSIS

18.1 His Honour Judge Jacobs accepted when sentencing Mr A in relation to the Deceased's death on 22 February 2010 that Mr A presented with *'features of emotionally unstable personality disorder, border line type'*. The Judge took the view that there was no evidence which suggested that Mr A was suffering from schizophrenia. The Judge also took the view that *'there is a … significant risk of serious harm from future specified offences likely to be committed by you'*.

18.2 Following his transfer to HMP Woodhill after the Deceased's death, Mr A was prescribed lithium, a mood stabiliser, and olanzapine, an antipsychotic, for approximately 2 weeks. Consultant Psychiatrist 6, a consultant psychiatrist at HMP Woodhill, was also of the view that Mr A had an emotionally unstable personality disorder.

19.0 MR A'S CONTACT WITH THE MHIRT BETWEEN 20 AUGUST 2007 AND 12 SEPTEMBER 2008

19.1 The Independent Investigation Team had access to Mr A's prison health records covering the period between 20 August 2007 and 12 September 2008.

19.2 The table below summarises a number of contacts which Mr A had with HMP Peterborough's Primary Care Team and the MHIRT. **The contacts which Mr A had with the MHIRT are shown in red and italics.**

Date	Event Detail
04 August 2007	Mr A admitted to HMP Peterborough. Urine screen positive for methadone, opiates & Subutex. Mr A admitted heroin use and stated that the Subutex had been prescribed to him.
20 August 2007	Mr A re-admitted to HMP Peterborough. Mr A admitted heroin use. Claimed to be using 2 bags of Heroin a day. Urine screen positive for opiates.
21 August 2007	Seen by a doctor. Put on Subutex detox and supportive medication.
07 September 2007	Mr A claimed to have been using heroin whilst in prison. Requested methadone and asked to be put on maintenance.
14 September 2007	Seen in nurse clinic regarding bruising to right hand following punching a wall two days previously. Mr A said he saw the doctor the previous day. Nothing was broken and his hand was just badly bruised. Paracetamol and Ibuprofen prescribed.
21 September 2007	*Entry by Team Leader 2:* *'Mr A is not known to services he was referred to Learning Disability service in 2006 by his GP he did not attend the appointment. He has never been admitted to ward 5. I believe he would benefit from CARAT intervention'*
29 September 2007	Mr A noted to be in prison for 2 months. History of mental health problems. Seen by a psychiatrist when in Bradford. Mr A requesting to see psychiatrist. History of self-harm. Complaining of sleeplessness, denied any suicidal thoughts. Prescribed promethazine 50 mg nocte [at night] for three days. Referred to

Date	Event Detail
	Mental Health In-Reach team.
13 October 2007	Called to attend Mr A. Mr A self-harmed by inserting a 2.5 cm length of wire into lower right quadrant of his abdomen. Prisoner taken to hospital in ambulance.
14 October 2007	Prison patient records state: 'Problem:- self discharge hosp after inserting wire into lower right abdo now increasing pain tenderness Examination:- generalized tenderness and guarding Intervention:- readmit wd3X'
15 October 2007	*Letter offering clinic appointment with Team Leader 2 and In Reach Nurse 1 of In Reach service*
15 October 2007	*Hand written entry Team Leader 2:* *'Checked with local agencies to ascertain whether Mr A is known. Last seen in 2003 – MHAT - no further input.'*
18 October 2007	*Handwritten entry by Team Leader 2:* *'Did not attend appointment'*
19 October 2007	*Letter from In Reach Team Team Leader 2 advising Mr A that because he did not attend appointment on 18 October 2007 that no further action would be taken unless he contacted In-Reach Team.*
October 2007	Mr A sentenced for driving offences.
30 October 2007	Mr A escaped from escort at Peterborough District Hospital.
9 November 2007	Mr A in fight. Force used on him, thumb swollen.
12 November 2007	*Letter from Mr A's solicitor to The Director/Healthcare Department states:* *'So far as the 2 year imprisonment sentence is concerned, we understand that the Sentencing Judge directed that a previous Psychiatric Report prepared by Consultant Psychiatrist 4 should be forwarded to the prison so that any issues raised in there may be*

Date	Event Detail
	dealt with. *We understand from the Inmate that nothing has happened in relation to any recommendations in that report. We therefore enclose a further copy [sic] order that it may be referred to your Health Care Section for any action that may be deemed necessary.'*
19 November 2007	*Letter to Mr A's solicitor from Team Leader 2 In Reach Team in response to letter of 19 November 2007 states:* *'Mr A reported to the Healthcare Reception Screening Nurse back in August 2007, that he was an inpatient and under the Mental Health Services in 2005. On checking with the local services, Mr A has never been admitted to Hospital nor has he been seen by the Psychiatrist.'* *'I sent a letter to Mr A acknowledging that he did not attend and that if his circumstances were that another appointment should be sent to inform the officer who will contact us.* *To date I have not received any notification from the officer or Mr A requesting another appointment.'*
20 November 2007	Mr A attended surgery after cell transfer. Broke flask and injured hand. At first refused treatment then requested that the wound be dressed.
22 February 2008	Mr A appeared depressed, offered mirtazapine 15 mg.
17 March 2008	Mr A admitted to sharing needles with other inmates. 'Taking iv heroin twice a day for the past 9 days last taken yesterday morning? 1 bag on a metal spoon…Blood taken for screening…wants to see Dr…'
1 April 2008	Admitted taking drugs while in prison. Agreed to taking lofexidine for 10 days. He was then urine tested for opiates and gave a negative result, at which point the lofexidine was cancelled.
17 April 2008	Mr A was physically sick and collapsed yesterday. He claims to have injected 6 mg Subutex just prior to the event.

Date	Event Detail
13 May 2008	Hit a wall causing right hand pain in knuckles. On examination – no sign of fracture.
6 June 2008	Agreed to try lofexidine for withdrawal symptoms.
23 July 2008	*MHIRT from CARAT.* *'Mr A used to see a psychiatrist in the community. It was Ceders[sic] & Gloucester Centre…He sent two referrals last year and appointments where[sic] cancelled. Mr A needs to see someone, as having witnessed his dad's murder as a 12 year old. This had an adverse effect.'* *'Currently on no medication - used to be on anti-psychotic and mood stabilizers.'* *'On IMS it states Mr A was former escapee also self harmed. But he has never been a problem or caused problems in our Department.'*
29 July 2008	MHIRT Meeting. The minutes of this meeting do not refer to Mr A despite a written referral to the service having been made by a member of the CARATS service on 23 July 2008.
6 August 2008	*Substance Misuse Practitioner 1 from MHIRT at HMP Peterborough contacted Mr A requesting background information.*
7 August 2008	*Signed consent form returned together with information that Mr A's GP was Dr O. The form states that he was prescribed mood stabilisers, anti-psychotic pills and anti-depressants, and had received counselling at the Cedars.*
12 August 2008	*Letter to Mr A advising him of appointment with MHIR service on 14 August 2008.*
14 August 2008	*Entry made by Substance Misuse Practitioner 1:* *'Mr A attended today's appointment with CARATS Worker 1 (CARATs). Mr A reported that he did not attend previous appointments due to visits and hospital appointments. Mr A is due for release 19.11.08 and has had numerous added days due to*

Date	Event Detail
	pos[itive] urine drug screens. *Mr A began using Heroin 8 years ago and Crack 4 years ago. Prior to prison Mr A was prescribed 8 mg Subutex – Bridgegate. He was placed on a 12 day detox of Subutex on arrival at HMP Peterborough. Mr A felt that it was far too quick and resulted in him using illicit drugs on the wing. Mr A currently admits to smoking 3 bags of heroin daily (approx 0.2 g). Mr A is also snorting 1 mg of Subutex daily. He very much wants to get out of the vicious circle of using and positive drug screens.* *Mr A states that he feels that he is coping pretty well on the wing but at times feels low and paranoid of others. Mr A also stated that he stopped his prescribed medication due to his chaotic lifestyle and drug use. He is currently using to avoid the discomfort of withdrawal and to block out any uncomfortable feelings and emotions. Drug Screen today – Pos[itive] for Subutex only.'*
19 August 2008	*MHIRT* *There is no mention of Mr A in the minutes of the 19 August 2008 meeting. Substance Misuse Practitioner 1 and Team Leader 2 were present at this meeting. Also present was Consultant Psychologist 1, a psychologist with a special interest in personality disorders.*
8 September 2008	*The entry in the MHIRT notes compiled by Substance Misuse Practitioner 1 in respect of this states:* *'Mr A was seen today. Broken right hand as a result of a fight with another prisoner on his wing. Drug-use discussed. Mr A has stopped taking heroin but continuing to snort 1 mg Subutex daily. Mr A says he takes this to avoid discomfort of any withdrawal. He also admits that without using he feels that the day would be long and empty. We have talked about commiting[sic] to attempt not taking Subutex and ways to deal with the discomfort of withdrawal – goal setting pro's and cons plus supportive meds. Mr A realises he has to make the decision and try to focus on the benefits of stopping. Mr A was due for release 19th Aug. Due to positive drug screens added days mean that release is now 21st Jan 2009.* *Drug worker from PDS - Bridgegate have visited Mr A, they will offer treatment following his release.* *Mr A reports that he is okay though sometimes feels paranoid that*

<table>
<tr><th>Date</th><th>Event Detail</th></tr>
<tr><td></td><td> officers are listening in through the intercom. Also recently having bad dreams. I will discuss treatment with detox nurse regarding treatment options and support Hep C / hiv screening – 3rd Sep 08.’ </td></tr>
<tr><td>9 September 2008</td><td> MHIRT Meeting. There is no mention of Mr A in the minutes of the 19 August 2008 meeting. Substance Misuse Practitioner 1 and Team Leader 2 were present at this meeting. Also present was Consultant Psychologist 1, a psychologist with a special interest in personality disorders. </td></tr>
<tr><td>11 September 2008</td><td>The Deceased attacked.</td></tr>
<tr><td>16 September 2008</td><td> MHIRT Meeting. It is not clear who was present at this meeting as the ‘Present’ and ‘Apologies’ section has not been completed. Mr A is mentioned at this meeting in the following terms: ‘Cases requiring In-reach advice - NOT OPEN Including decisions to open - re-open cases’
<table>
<tr><th>Name</th><th>Issues Raised</th><th>Action</th></tr>
<tr><td>Mr A</td><td>Transferred out 12/09</td><td>To speak to Team Manager 1. Notes to Consultant Psychiatrist 5.</td></tr>
<tr><td>Mr B</td><td>Ditto above</td><td></td></tr>
</table></td></tr>
</table>

20.0 MR A'S REFERRAL TO THE MHIRT

20.1 The Independent Investigation Team did not have an opportunity to interview Mr A. In any event, it is not the function of an Independent Investigation Team to 'second guess' clinical decisions made by those responsible for providing care.

20.2 However, in relation to Mr A's case, no diagnostic process was employed. There are several points during the course of Mr A's involvement with the MHIRT at HMP Peterborough at which a diagnostic process could have been employed to assess Mr A. These are set out below.

20.3 Reception

20.4 An assessment of the physical and mental health care needs of prisoners when they first arrive at prison is a statutory requirement set out in Prison Service Standard 24: Health Services for Prisoners (H.M. Prison Service, 2000). At HMP Peterborough in 2008, this task was not carried out by CPFT or any of its staff.

20.5 Mr A was screened upon reception on 4 August 2007 by a Healthcare Assistant. The following information was recorded:

Prisoner receiving prescribed medication	*'Yes Sabutex[sic] 6mg od [once daily]'*
Prisoner has used drugs in the last month	*Heroin*
Prisoner has concerns over their physical health	*'Yes suffers from panic attack sometimes'*
Prisoner has stayed in a psychiatric hospital	*'Yes Edith Cavel[sic] Hosp Ward 5 in 2005'*
Prisoner tried to harm themselves (outside prison)	*No*
Prisoner tried to harm themselves (inside prison)	*No*
Prisoner has received medication for mental health problems	*'Yes Mood stabiliser not sure of the name in 2005'*

20.6 A recognised obstacle to the effectiveness of the reception screening process in detecting mental health issues amongst prisoners is the fear of the discrimination that a mental health diagnosis can cause for an individual in prison. Status and peer

pressure are powerful influences in prison and can hamper the depth of disclosure which is given to medical staff. In addition, those who disclose information run a risk that they might be subjected to a more intensive regime of observation, particularly in relation to drugs. It is therefore interesting that Mr A was prepared to disclose a possible admission to hospital. He did not, however, disclose any details of any self-harming incidents.

20.7 Incidence of self-harm

20.8 On 14 September 2007 Mr A's notes relate to an incident of self-harm/violence by Mr A. The notes state:

> *'Seen in nurse clinic regarding bruising to Right Hand following punching a wall two days ago. Said he saw the doctor yesterday, doctor advised that nothing appeared broken and that it was just badly bruised. Advised to take paracetamol and Ibroprufen.'*

20.9 It is unclear from Mr A's records whether the reception screening process led to Mr A being referred to the MHIRT or whether it was the incidence of self-harm/violence. This meant that it was approximately six weeks following his arrival in prison that Mr A first came to the attention of the MHIRT. During this time his potential treatment needs remained unrecognised. The possibility of prisoners slipping under the radar in this fashion was highlighted in interview with Team Leader 1, the current MHIR Team Leader:

> *'Team Leader 1:*
>
> *Yes, feeding back to us as well. And overall staff do that they are very good. Our response is that the duty worker picks it up and gets the ball rolling. If people, my concerns are more really around when people come in and we don't get alerted to them at the beginning when they come in. And then they spend six to eight weeks bubbling away and become very ill. Because we have not been alerted and the sad thing about prison is, is that if you're quietly bubbling away nobody notices you because you're not a management problem.'*

20.10 Background checks

20.11 A note by Team Leader 2 of the MHIRT was made in Mr A's MHIRT notes on 21 September 2007. The notes confirm that Team Leader 2 had made a number of background checks upon Mr A. The entry makes reference to the fact that these investigations showed that Mr A was not known to services nor had he been admitted to Ward 5, which the Independent Investigation Team understand to be a local in-patient unit. Team Leader 2's suggested course of action was that Mr A be referred

to CARATS (Counselling, Assessment, Referral, Advice and Throughcare Services). The exact nature and extent of the checks undertaken by Team Leader 2 are not recorded in Mr A's records.

20.12 Request by Mr A to see a Psychiatrist

20.13 Mr A was referred to the MHIRT by prison healthcare on 29 September 2007. He gave a history of mental health problems and self-harm. He asked to see a psychiatrist. He was complaining of sleeplessness at this stage but denied any suicidal thoughts.

20.14 Self-harm

20.15 Following a further episode of self-harm on 13 October 2007, Mr A was sent an appointment for 18 October 2007 by the MHIRT. The episode of self-harm involved Mr A inserting a 2.5 cm length of wire into his abdomen, requiring hospital treatment.

20.16 Mr A's notes show that Team Leader 2 made further attempts on 15 October 2007 to find out more about his background. Her conclusion was that Mr A was not known to mental health services in the area. Issues surrounding information management are more fully dealt with in Section 23.

20.17 Failure to attend appointment

20.18 When Mr A failed to attend his appointment on 18 October 2007, he was not offered a further appointment. Team Leader 2 was asked about this in interview. The decision not to offer a follow up appointment was explained in the following terms:

'JH: And you are not going to offer any follow-up. So really he was only getting one crack at it?

Team Leader 2:
At the time.

JH: At the time.

Team Leader 2:
Because of resources, that's now changed of course.

JH: So that was because of, and was that a standard thing?

Team Leader 2:
Yes.'

20.19 Psychiatric Report

20.20 On 12 November 2007, Team Leader 2 received a letter from Mr A's solicitors. This letter enclosed a psychiatric report dated 26 February 2004 containing recommendations for the ongoing management and treatment of Mr A. The letter stated:

> *'So far as the 2 year imprisonment sentence is concerned, we understand that the Sentencing Judge directed that a previous psychiatric report prepared by Consultant Psychiatrist 3 should be forwarded to the prison so that any issues raised in there may be dealt with.'*

20.21 The report sets out Mr A's history of involvement with services. It also refers to a parental history of paranoid schizophrenia, special educational provision, and a self-report of attempted strangulation of a child. '*Some time in the past, he apparently lashed out at his son and tried to strangle him*'. Mr A also self-reported possible psychotic phenomena: '*He admitted on many occasions experiencing self-referential ideation, being suspicious and getting paranoid about people and thinking that they were talking about him. This often made him have aggressive/homicidal thoughts. He also admitted to hearing occasional voices calling out his name*.'

20.22 Consultant Psychiatrist 3's conclusion was that Mr A was displaying an emotionally unstable personality disorder, borderline type. He did not consider that Mr A's apparent psychotic features fulfilled the criteria for schizophrenia, but noted that there were risk factors which indicated that such an illness might develop. He recommended a package of care comprising further psychological and psychiatric input, the latter possibly to include psychotropic medication in the form of combined antipsychotic and mood stabilising medication.

20.23 It is the view of the Independent Investigation Team that the information provided in the psychiatric report of 26 February 2004 should have prompted a review of the treatment offered to Mr A and attempts to re-engage him with the MHIRT should have been made. Mr A's case was of considerable complexity and, having regard to the fact that this was a report from a psychiatrist making recommendations as to Mr A's ongoing care and treatment, it is the view of the Independent Investigation Team that this should at least have warranted discussion with the MHIRT psychiatrist or been discussed at the MHIRT weekly meeting. The failure to do so is a significant matter of concern for the Independent Investigation Team.

20.24 Team Leader 2 responded to the solicitor's letter on 19 November 2007. Her letter records that Mr A had been offered an appointment on 18 October 2007 but had failed to attend. She stated that Mr A had been informed in a letter that, should he wish for another appointment, he should apply via his Wing Officer.

20.25 Further request to see a Psychiatrist

20.26 On 22 February 2008, when Mr A presented as appearing depressed, he was offered the antidepressant drug mirtazapine by a health worker working outside the MHIRT. This might have afforded an opportunity to arrange an assessment by the MHIRT but the opportunity was missed by the individual who performed the assessment.

20.27 On 17 March 2008, when consulting about his drug problem, Mr A said that he wanted to see a doctor. There was a missed opportunity to offer him an appointment with the MHIRT's psychiatrist.

20.28 On 13 May 2008, Mr A attended the prison GP having punched a wall. The medical record reads '*Hit the wall with right hand, pain in knuckles, O/E no sogns [sic] of fracture, Superficial bruising*'. There is no record of this being brought to the attention of the MHIRT or of it being considered as relevant to any risk assessment.

20.29 On both these occasions, Mr A was assessed by individuals who were not qualified to fully assess the importance of the symptoms being exhibited by Mr A in the context of the psychiatric report referred to at Paragraph 20.19, even if that report had been available within Mr A's records to which they had access. As a result, an opportunity was missed for a detailed assessment.

20.30 The decision not to offer Mr A a further appointment was made as a result of limited resources. The Independent Investigation Team recognise that resources have to be carefully managed. However, the Independent Investigation Team noted that in HM Inspectors Inspection Report dated July 2011 that problems associated with the organisation of appointments was contributing to a high DNA rate (see Paragraph 10.15). A system which allows a patient only one opportunity to be seen must be supported by robust administrative systems to ensure that the patient is afforded that opportunity. In any event, the MHIRT has redeveloped and strengthened its referral pathways.

20.31 In October 2011, the MHIRT established Alert Clinics. These clinics are used as a type of 'triage' clinic. Prisoners can be seen rapidly as a result of referrals from a variety of sources, including self-referral and referral from wing officers. This greatly

improves access to the service and demonstrates an element of good practice which was not present at the time of Mr A’s care.

20.32 Alert clinics were launched primarily to solve the problem of increasing demand on the MHIRT due to limited resources, but with the additional function of enhancing the quality of the service offered to both prisoners and staff by increasing face to face interactions with prisoners and making assessment decisions based on these interactions rather than though a paper screening process.

20.33 THE MHIRT offers a male clinic once a week. Four half hour appointments are offered in the clinic each week. As alerts are received by the team administrator, they are logged on a data base, reviewed briefly at the team meeting for any urgency or immediate risks and allocated the next available clinic slot. No further paper screening over and above this takes place thereby freeing MHIRT staff time to focus on the ongoing caseload.

20.34 Prisoners are contacted by letter, giving notification of their clinic appointment time; the letter contains a ‘tear off’ slip at the bottom which the prisoner can use to inform the team of any difficulties with the appointment time (due to visits etc.) or if they wished to decline the appointment. A general information form is also included, which the prisoner is asked to complete prior to the appointment, this contains personal information (community GP details, information regarding previous mental health treatment) and also allows space for the prisoner to state what his/her main difficulties are and how they think the mental health team can help them.

20.35 All members of the MHIRT are involved in running the clinics. A brief screening tool has been devised in order to gather key information in order to detect possible mental health problems, (current symptomology, biological markers, family history of mental disorder, risk, previous contact with services and goals).

20.36 All prisoners attending the clinics are also asked to complete a GHQ-12. This is a 12 item screening tool devised to identify individuals most likely to meet the threshold criteria for mental health problems.

20.37 The aim of the clinic is to provide a brief face to face screening assessment in order to determine quickly and efficiently whether further mental health assessment is necessary.

20.38 Following the clinic appointment, a brief report is sent back to the GP. The GP is informed that an alert had been received, the prisoner has been screened and the

outcome of that screening. If further assessment is required the screening is discussed at the next MHIRT meeting and the prisoner is allocated to a member of the MHIRT for further assessment.

20.39 During the course of interviews with key members of the current MHIRT, confirmation was given that referral to an alert clinic could be made following receipt of a letter such as that referred to at Paragraph 20.19 above, an incident of self-harm or a request made by a prisoner himself.

20.40 The establishment of Alert Clinics provides the Independent Investigation Team with evidence that learning has been taken and actioned from the Deceased's death.

20.41 It is encouraging to note that *'An evaluation of the First 6 Months of MHIR Alert Clinic'* was undertaken on 9 May 2012. This evaluation was conducted by current practicing members of the MHIRT and not by members of CPFT's Clinical Governance Team.

20.42 The evaluation identified the following learning:

- *'While the alert system allows Officers and Sodexo Staff a direct route to the MHIR Team for screening, the dual system of Alerts and referrals may prove confusing for some (i.e. GP's using both systems and using Alerts for 'Less serious' problems) we may need to consider one single pathway, such that all prisoners referred to the team are screened via one process. This may mean the introduction of further clinics;*
- *MHIRT need to check that the alerted prisoner is not already under any other services such as IDTS prior to sending the appointment. MHIT have now taken steps to ensure that these checks are carried out and that communication between services is robust;*
- *Officers should continue to seek prisoners consent to alert the MHIR team, this may help reduce those refusing to attend;*
- *There was some duplication of alerts, with may[sic] alerts being received for the same prisoner. Although the MHIT generally interpreted this as 'high priority', consideration could be given to using NOMIS in order to identify that an alert has been made;*
- *There was some inappropriate use of the alert system for example prisoners requesting to see mental health in order to get a 'single cell' or 'HDC eligibility', prison staff should avoid using the system for these purposes.'*

The Alert Clinic Evaluation does not identify which members of staff are responsible for assessing service users referred to the Clinics but does state that *'all members of the MHIRT were involved in running the clinics'.* Potentially this is a matter of concern, as discussed further at Paragraph 21.52.

20.43 A further issue arises in relation to the Alert Clinic Evaluation, in that the quality of clinical decisions taken within the clinic was not considered. As a newly introduced feature of the MHIR Service, this should also be the subject of ongoing review and audit. Decisions taken in this clinic may be of crucial importance to individual prisoners and it is therefore essential that decisions taken are of an appropriate standard and are consistent. It is equally important that there is a secure audit trail relating to each of these decisions to maximise quality assurance. In particular, it may be necessary to record criteria/rationale for refusal of the patients who were not accepted into MHIRT and audit if this rationale is consistent across clinicians and whether it matches the exclusion/inclusion criteria.

20.44 The MHIRT has taken steps to educate those involved in the prison about Alert Clinics in order that those individuals who have a concern about a prisoner can access the MHIRT. However, a concern which the Independent Investigation Team has identified with the Alert Clinics at present is that their processes and procedures are not fully documented and are therefore open to interpretation by MHIRT members. This is a critical weakness that is again reminiscent of the culture which operated within the MHIRT at the time of the Deceased's death and is a cause for concern given the importance of the Alert Clinic function. CPFT has advised the Independent Investigation Team that a protocol for the Alert Clinic is to be developed and incorporated into the MHIRT Operational Policy.

20.45 The Independent Investigation Team understands that the MHIRT have helped to re-evaluate the Reception Screening processes operated by prison healthcare staff. The processes have been strengthened with a view to increasing the likelihood of identifying individuals with mental health needs upon arrival at HMP Peterborough. This is an element of good practice and learning.

20.46 Key Points

1. Mr A was screened upon Reception at HMP Peterborough on 4 August 2007 by a healthcare assistant. During his assessment, Mr A revealed that he had been admitted to a psychiatric unit in 2005. He also advised the healthcare assistant that he had substance misuse issues.
2. Mr A was subsequently referred to the MHIRT, although the referral process is unclear.
3. On 21 September 2007, a number of background checks on Mr A were carried out by the MHIRT. These checks purportedly showed that Mr A was not known to mental

health services. The nature and extent of these checks are not included in Mr A's records. Mr A's records show that the MHIRT suggested his referral to CARATS.

4. On 29 September 2007, Mr A's records show that he had asked to see a psychiatrist due to sleeping difficulties.
5. Further, on 13 October 2007, Mr A's notes record a further incidence of self-harm when Mr A inserted a 2.5 cm length of wire into his abdomen.
6. Mr A was sent an MHIRT appointment for 18 October 2007. Further background checks were undertaken in advance of this appointment. The MHIRT again reached the view that Mr A was not known to mental health services in the area.
7. Mr A did not attend his appointment with the MHIRT on 18 October 2007. In line with MHIRT policy at that time he was not offered a further appointment.
8. The MHIRT received a letter from Mr A's solicitors on or around 12 November 2007 advising that a judge involved in sentencing Mr A had asked that a psychiatric report dated 26 February 2004 be taken into account in his future management. The MHIRT response to this letter was that Mr A had failed to attend an appointment with the service. He was therefore responsible for seeking a further appointment with the service through his wing officer. The Independent Investigation do not believe this was an appropriate response due to the complexity of Mr A's presentation revealed in the Psychiatric report dated 26 February 2004. The Independent Investigation Team believes that Mr A should have been offered an appointment with the MHIRT psychiatrist at this time and/or had his care discussed in a multidisciplinary context.
9. On 22 February 2008, Mr A was seen by a health care worker outside the MHIRT. Mr A was complaining of symptoms of depression. Mr A was not referred to the MHIRT but was instead offered anti-depressant medication.
10. Further, on 17 March 2008, Mr A attended an appointment with a prison health care worker. On this occasion, Mr A again asked to see a psychiatrist.
11. Both of these appointments involved Mr A being assessed by individuals who were not qualified and who would not have been able to assess the importance of the symptoms exhibited by Mr A when placed in the context of the psychiatric report referred to at Paragraph 20.19 above, even if that report had been available to them.
12. The MHIRT has introduced Alert Clinics to increase access to its services. This is an element of good practice and addresses an issue of accessibility arising out of Mr A's care.
13. When a patient is seen in an Alert Clinic, and it is thought that further assessment is required, information is gathered on that individual which is then discussed in the MHIRT meeting. This ensures a degree of multidisciplinary working. However, the position is less clear as to what happens when the patient is screened and it is

determined that no referral to the MHIRT is necessary. The MHIRT Draft Operation Policy states that, 'All referrals are discussed at weekly team meetings.' However, the Evaluation of the first 6 months of MHIRT Alert Clinics' appears to suggest that in fact, if a patient is not assessed as requiring a referral to MHIRT, their case is not discussed in a MDT setting. This is a matter of concern.

14. The processes and procedures relating to the Alert Clinic have not been written down in a single source document. This represents a significant control weakness.

20.47 Additional Learning

1. The MHIRT has introduced an element of good practice into its operational procedures by adopting the Alert Clinic. However, there remains a lack of clarity in relation to those procedures and important fail-safes such as discussion of a screener's assessment of patients not deemed to require MHIRT care by the MDT require consideration.
2. However, the processes surrounding the Clinics have not been formalised at the time of this Report. Written procedures, whilst being less flexible, do have the advantage of clarity for those involved in delivering the service. There is less room for misunderstanding and consistency is more readily obtained. It also assists in the current audit process.
3. Given that the Alert Clinic is a new feature, the Independent Investigation Team believe that there would be merit in CPFT's governance team performing a clinical audit in order to ensure that the clinical decisions taken in the clinics are of an appropriate standard and are consistent.

21.0 CLINICAL CARE PROVIDED BY THE MHIRT

21.1 Referral to MHIRT by CARATS

21.2 CARAT prison drug services are designed to identify people in the prison system who misuse drugs and take them through the treatment process from start to finish, including through release from prison and their journey back into the community. The CARAT service offers various options, including one-to-one interventions by workers trained in basic counselling techniques such as cognitive behaviour therapy ('CBT'), motivational interviewing and brief strategic family therapy.

21.3 On 23 July 2008 Mr A was referred to the MHIRT by CARATS Worker 1 of the CARATS Team. The referral form reads:

> *'Mr A used to see psychiatrist in the community It was Ceders [sic] & the Gloucester Centre at Shrewsbury AV, Woodston. He sent two referrals last year and appointments were cancelled. Mr A needs to see someone as having witnessed his dad's murder as a 12 years [sic] old. This had an adverse effect.'*
>
> *'currently on no medication – used to be on antipsychotic and mood stabilisers.'*

21.4 Consultation with Substance Misuse Practitioner 1

21.5 Mr A was contacted by the MHIRT by letter on 12 August 2008 and was offered an appointment with Substance Misuse Practitioner 1, a substance misuse practitioner.

21.6 Substance Misuse Practitioner 1's first consultation with Mr A took place on 14 August 2008. The entry relating to this meeting reads; '*Mr A states that he feels that he is coping pretty well on the wing but at times feels low and paranoid of others. Mr A also stated that he stopped his prescribed medication due to his chaotic lifestyle and drug use. He is currently using to avoid the discomfort of withdrawal and to block out any uncomfortable feelings and emotions.*'

21.7 The entry also states '*I will discuss treatment with detox nurse regarding treatment options and support.'*

21.8 On 8 September 2008 Mr A attended a further consultation with Substance Misuse Practitioner 1. Mr A was reported to have been involved in a fight with another inmate resulting in a broken hand. There is no evidence that this was considered as part of an updated risk assessment. The note also states:

> *'Mr A reports that he is okay though sometimes feels paranoid that officers are listening in through the intercom. Also recently having bad dreams.'*

21.9 Mr A was offered an appointment with the MHIRT on 22 September 2008. However, Mr A was transferred out of HMP Peterborough before this time as a result of the attack on the Deceased and his subsequent death.

21.10 Substance Misuse Practitioner 1 had worked at the prison since September 2007. Prior to joining HMP Peterborough MHIRT, Substance Misuse Practitioner 1 had been employed as a Nursing Assistant in a psychiatric ward and as a Substance Misuse Practitioner in the community. She had no previous experience of working in a prison environment. Substance Misuse Practitioner 1 has no formal qualifications relating to substance misuse or mental health. At the time of the Deceased's death, Substance Misuse Practitioner 1 did not have a job description setting out her duties and the arrangements attaching to her supervision. This issue has now been addressed.

21.11 During the course of interviews with the Independent Investigation Team, Substance Misuse Practitioner 1 described her role within the MHIRT as being unclear in 2008. She explained she would receive cases from Team Leader 2 or In Reach Nurse 1, a mental health nurse with the MHIRT, which involved patients with substance misuse issues. In 2008, she had her own case load without a mental health nurse being assigned to her patients. Consequently, her case load was not the subject of appropriate supervision.

21.12 Substance Misuse Practitioner 1 saw Mr A on 14 August 2008 and 8 September 2008. She already had limited knowledge of him as a result of working as a Substance Misuse Practitioner in the community, but had not been involved in his treatment previously. In interview, Substance Misuse Practitioner 1 explained to the Independent Investigation Team that Team Leader 2 had asked her to see Mr A concerning his substance misuse issues. At the time, Substance Misuse Practitioner 1 confirmed that there was no formal process for determining which prisoners were suitable for her to see without a qualified clinician.

21.13 Substance Misuse Practitioner 1 did not record her findings from either consultation using CPA documentation provided by CPFT. This did not accord with CPFT policy at the time.

21.14 In interview, Team Leader 2 was asked about the rationale behind asking Substance Misuse Practitioner 1 to see Mr A. Her response was as follows:

'Team Leader 2:

I think she I think she saw him on her own after seeing him with CARATS Worker 1 because I think in the referral CARATS Worker 1 sort of saying he's not a problem, he's sort of an escape artist but he's not a problem risk wise so he's not done anything. And I just, I remember saying to her jump on that see if you can jump on that and see what you think.

TC: OK with the idea of what?

Team Leader 2 :

Well she's, I appreciate she's not qualified but she's very good and if she'd have any concerns she would have come straight back and said I think you need to see him.

TC: OK.

Team Leader 2:

Whereas now, well, now anybody that Substance Misuse Practitioner 1 sees automatically is joint worked, it's not, you know, we've learn from the SI, learnt from that you know cos that was probably in some way my fault but I just thought there's an opportunity there jump in on that interview with the CARAT worker see what you think now anybody that we're not too sure about, that there is a big illicit substance history then we drug work.'

21.15 During the course of the interviews, the Independent Investigation Team were advised that there were no formal referral processes in place at the time of Mr A's care. However, it is clear that team meetings had been established with the service. Those team meetings included a slot at which new referrals could be discussed.

21.16 During the course of the Independent Investigation, minutes from a number of MHIRT meetings were brought to the attention of the Independent Investigation Team. The Independent Investigation Team has had an opportunity to review the minutes of these meetings which relate to the period between 1 July 2008 and 16 September 2008. The following points are relevant to Mr A's care.

21.17 Team Meeting - 29 July 2008

21.18 The minutes of this meeting do not refer to Mr A despite a written referral to the service having been made by a member of the CARAT Service on 23 July 2008. The minutes of this meeting do however, contain reference to the structure and recording of minutes from team meetings in the following terms:

'Went through minutes of last meeting. In view of the new format, pointed out that there may well be teething problems with it initially but that we would work our way through. Although the minutes had been typed up, they had not been approved or circulated due to volume of workload and staff shortages.'

21.19 In relation to this meeting, the format of the meeting had been changed. The minutes were more structured with the meetings being broken down into the following constituent parts:

- Minutes of last meeting;
- New Referrals;
- Feedback from assessments;
- Mental Health Act Assessments;
- Mental Health Act Transfers tracking data;
- Assessment waiting list review;
- Current cases discussed at meeting;
- Cases closed to MHIRT;
- Complex cases;
- General Feedback;
- Any other business;
- Date of next meeting.

21.20 The minutes following this meeting confirm that this format was broadly adhered to in relation to the following meetings.

21.21 Team Meeting - 19 August 2008

21.22 There is no mention of Mr A in the minutes of the 19 August 2008 meeting despite him having been seen by Substance Misuse Practitioner 1 on 14 August 2008 following receipt of his appointment letter dated 12 August 2008. Substance Misuse Practitioner 1 and Team Leader 2 were present at this meeting. Also present was Consultant Psychologist 1, a psychologist who the Independent Investigation Team has been advised has a special interest in personality disorders.

21.23 It is clear that by this stage it had been recognised that there was a need to identify individuals who were in receipt of services from the MHIRT, as it was unclear which prisoners were under the care of the MHIRT. In particular, under the section entitled 'Any Other Business' it states:

'Filing system to be rearranged, all open cases as identified by the team to be placed in one filing cabinet in alphabetical order. No distinction between male and female open cases needs to be made

Consultant Psychologist 1 and SMoh have been working towards identifying an active caseload to identify clients to be included in the in-reach survey. A working list of male and female clients will be distributed among the team in order to clarify the accuracy of the list

Care Records System - All cases will be recorded on CRS, this has now been agreed. May need to decide what team name our clients will come under in order to protect their prison status

Assessment structure - it was agreed that the team would look at a standardised structure to initial assessments - team to bring examples of previous structures to next team meeting'

21.24 It is clear that work had commenced on producing a definitive case load list for the MHIRT by 21 August 2008. By this date a draft list identifying those prisoners who were receiving care from the Team had been circulated to Team members. However, Mr A's name was not on the draft list which was circulated.

21.25 Team Meeting - 9 September 2008

21.26 Under the section headed 'New Referrals', the Independent Investigation Team noted that there was no mention of Mr A's referral to the MHIRT by CARATS on 23 July 2008 despite Team Leader 2, Consultant Psychologist 1 and Substance Misuse Practitioner 1 all being present at this meeting. Substance Misuse Practitioner 1 wrote to Mr A on 9 September 2008, offering Mr A a further appointment.

21.27 However, the Independent Investigation Team noted that there was evidence that Substance Misuse Practitioner 1, an unqualified practitioner, was responsible for 'screening' other new referrals at this time. For example, the minutes state:

'Mr B Referred by Consultant Psychiatrist 2 PD? To Substance Misuse Practitioner 1 for screening'

'CH Referred by Consultant Psychiatrist 2 Substance Misuse Practitioner 1 Seen Joint with Carats'

21.28 Team Meeting - 16 September 2008

21.29 It is not clear who was present at this meeting as the 'Present' and 'Apologies' section has not been completed. Mr A is mentioned at this meeting in the following terms:

‘Cases requiring In-reach advice - NOT OPEN Including decisions to open - re-open cases’

NAME	ISSUES RAISED	ACTION
Mr A	Transferred out 12/09	To speak to Team Manager 1 notes to Consultant Psychiatrist 5
Mr B	Ditto above	

21.30 A number of issues arise from the manner in which Mr A’s contact with the MHIRT was managed.

21.31 Substance Misuse Practitioner 1 should not have been asked to review Mr A’s case. Substance Misuse Practitioner 1, whilst being a caring and diligent substance misuse practitioner, is not a qualified mental health practitioner and should not have been delegated a function which she was not qualified to perform.

21.32 The Independent Investigation Team is concerned about the failure to discuss Mr A’s case at MHIRT meetings at which Team Leader 2, Substance Misuse Practitioner 1 and Consultant Psychologist 1, a psychologist with a special interest in personality disorders, were present. This deprived Mr A’s case of the benefit of multidisciplinary discussion and approach and indeed consideration of the necessity for a structured approach to risk management.

21.33 Furthermore, Mr A’s allocation to a substance misuse practitioner meant that there was a failure to consider Mr A’s overall mental health problems. It also denied the MHIRT of an opportunity to conduct a structured risk assessment. It is clear from the psychiatric report prepared by Consultant Psychiatrist 3 in 2004 that Mr A had a complex presentation of which only one aspect related to substance misuse and which realistically should initially have been referred to a consultant psychiatrist or for discussion in a multidisciplinary context in order to establish an appropriate package of care.

21.34 A further concern which the Independent Investigation Team has is that at a time when the MHIRT was attempting to establish the true nature of its case load due to difficulties in its referral pathway, Mr A’s name appears to have been omitted from the database which was being complied, despite his existence being known to two members of the MHIRT. This had implications for the quality of Mr A’s care as it

caused him to fall outside any clinical governance regime that was in place within the MHIRT.

21.35 The MHIRT has carried out a significant amount of work following the Deceased's death to ensure that it has an accurate record of patients who are currently receiving care and those who have been discharged.

21.36 Systemic changes have been made. A referral book is maintained which includes discharge data. An alerts book is also used to record key information about referrals and discharge details. This is a significant improvement over the situation which existed when Mr A and Mr B were involved with the MHIRT. The Independent Investigation Team is of the view that further improvement will be possible through the planned introduction of an electronic care records system to increase transparency and facilitate an audit trail.

21.37 The reasons for the apparent reluctance of the MHIRT to accept Mr A into its service are unclear given the eligibility criteria outlined in the MHIRT Operational Policy (see Paragraph 14.4). However, the information available to the MHIRT at the time of Mr A's referral, including the information contained in Consultant Psychiatrist 3's report dated 26 February 2004, raised the possibility that Mr A had a potential personality disorder and that he should be monitored for emerging mental illness. He was experiencing substance misuse issues.

21.38 Personality disorders are relatively neglected so far as interventions are concerned. They affect many people in society, most of whom do not commit offences. For some, however, personality disorder significantly contributes to offending and risk related behaviours. Approximately two-thirds of prisoners meet the criteria for at least one type of personality disorder. There is a link between personality disorder and a high risk of serious harm to self and others.

21.39 People with personality disorder are often the subject of discrimination. Access to services in prison and in the community is often denied, because they are stigmatised and regarded as a more difficult group with whom to work. Where mental health professionals are also restricted by funding issues and/or an excessive caseload, persons with personality disorders may be considered a low priority. It therefore appears that people with personality disorder, either on its own, or in combination with another mental health problem such as another mental disorder or substance misuse issues, have poorer outcomes, function less well in society and

are stigmatised by clinicians in secondary services, reducing the odds that they will receive an acceptable level of care.

21.40 It is clear that the forensic and medical history revealed in the Psychiatric Report dated 26 February 2004 and which was available to the MHIRT, indicated a potential diagnosis of borderline personality disorder, with a high level of supervision required for any signs of further emergent mental illness. While Mr A's substance abuse issues may have acted as a complicating factor, drug or alcohol abuse may indicate self-medication by an individual with a personality disorder and therefore warrant full clinical evaluation.

21.41 Individuals with Borderline Personality Disorder or trauma often use substances as a way of self-medicating to avoid difficult emotions or flashbacks. Therefore, Borderline Personality Disorder patients, as well as being provided with a methadone prescription or gradual detoxification, require alternative coping strategies while their maladaptive coping strategy (i.e. mind-altering substances) is removed. Strategies such as emotional regulation and distress tolerance from dialectical behavioural therapy can be used and have been shown to be effective in some research. However, treatments like this are widely under-resourced in prison settings.

21.42 The MHIRT Operational Policy dated September 2005 states that the following diagnoses will be accepted for care by MHIRT:

> *'a dual diagnosis where the primary diagnosis is a major mental illness';* or
>
> *'a personality disorder and presents with: severely impaired functioning and/or significant self-harm.'*

21.43 Dual diagnosis is the term used to describe people who have concurrent mental health and substance misuse or alcohol problems. This combination affects a third of mental health service users, half of substance misuse service users and 70% of prisoners.

21.44 It appears to the Independent Investigation Team that, despite the problems which are outlined in Consultant Psychiatrist 3's report and that in the Independent Investigation Team's view required further investigation, only Mr A's substance misuse problems were recognised. This is a matter of concern.

21.45 Unfortunately, substance misuse also has a negative stigma, which may result in mental health services being negatively biased against bringing such individuals into their services. This causes individuals such as Mr A to find themselves on the

periphery of mental health services, and therefore reduces the likelihood of uncovering an Axis I mental illness or Axis II personality disorder which may be a causative or maintaining factor of a substance misuse problem.

21.46 If an individual has a mental health diagnosis and a substance misuse problem then both these difficulties should be flagged up and treated by the most appropriate service. There is no reason why an individual cannot access CARATS/IDTS and a MHIRT jointly. However, historically, substance misuse is treated first and then any underlying mental health issues are dealt with.

21.47 CARAT workers are substance misuse practitioners who are not qualified in mental health. Therefore CARATS are expected to turn to a MHIRT for assistance with the broader mental health aspects of a prisoner's care.

21.48 The Integrated Drug Treatment System ('IDTS') was set up at HMP Peterborough in January 2010 in order to assist in the treatment of prisoners with substance abuse issues and reduce drug-taking inside prisons. Its role is described as:

> *'The integrated drug treatment system (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:*
> *early custody;*
> *improving the integration between clinical and CARAT Services; and*
> *reinforcing continuity of care from the community into prison, between prisons, and on release into the community.'*

21.49 HMP Inspector of Prisons in 2011 reported positively on the IDTS in HMP Peterborough saying:

> *'A full-time and highly experienced dual-diagnosis nurse worked closely with the CARAT and IDTS teams and the mental health in-reach team. Her liaison work with a wide range of community agencies improved throughcare and resettlement opportunities for dually-diagnosed prisoners on their release.'*

21.50 Until recently the IDTS had included a qualified mental health nurse who determined whether patients referred to IDTS also needed MHIRT intervention. This individual has now left the IDTS service.

21.51 During the course of their interview with members of the Independent Investigation Team, the current Team Manager of the MHIRT explained the current approach which would be taken in relation to a prisoner who presented to the MHIRT with similar issues to those experienced by Mr A. She explained that Mr A would now be

offered an appointment by the MHIRT to be seen in the Alert Clinic run by the MHIRT. This is a significant development in the service provided by the MHIRT and represents an element of good practice. She also stated:

'Team Leader 1:

He (Mr A) would be seen by a mental health practitioner. We would actually look at what actual pathway it was, I mean this gentleman might say well I saw, I saw a psychiatrist in Bradford prison so we would say right well we'll get that information, so we would be contacting saying do you know this gentleman, could you give us information. So that, we would try and get the history. But he would go into an alert clinic so the GP, coz he's got those two sort of options now. We would see him and so he would been seen quicker but it would not be a full mental health assessment it would be more of a mental health information gathering. But also if this man, if it became blatantly clear and he was saying that everything was around my drug misuse, I'm still using. We would be looking at referring him to the dual diagnosis practitioner in the IDTS because we'd want to have that sort of support and advice. Does the drug problems need dealing with before we can do sort of mental health work with him before we can offer any other interventions.'

21.52 The Independent Investigation Team is concerned by this. If Mr A came to the MHIRT now via referral from CARATS or IDTS an assessment should be undertaken by a qualified member of the team with the required experience. An information gathering exercise such as that undertaken in the Alert Clinic as outlined above is not sufficient. Regardless of whether the IDTS nurse is trained in mental health, a referral has been made to MHIRT for a specialist opinion. An assessment should therefore be made by a qualified mental health professional, particularly in the case of someone who has such complex needs as Mr A. The Independent Investigation Team have been advised by CPFT that *'new assessments, including for prisoners referred by IDTS or CARATS, are now carried out by qualified mental health professionals.'*

21.53 The Independent Investigation Team has a further concern in this regard. In interview, the current MHIR Team Leader was asked:

'KR: OK, so lets suppose you have this brief intervention with him in which you establish that it seems that the problems are mainly drug related and you refer him to IDTS and he, so he's not on your actual case load

Team Leader 1:

Our colleague the substance misuse practitioner. One of the roles she took on when they actually brought in the IDTS Mental Health Nurse was that she supported that nurse and did clinics with them, so that there

was a more clear sort of sharing of information, so we were able to pick up people or move people through to her.'

21.54 Substance Misuse Practitioner 1's role was then further clarified:

'Team Leader 1: ..

.so if this gentleman was being seen by the IDTS person, the clinic, she would be doing the clinic with Substance Misuse Practitioner 1.

JH: Right

Team Leader 1:

Was what Substance Misuse Practitioner 1 was doing and its quite, and quite a number of the people that the IDTS nurse saw were not under us. But she was offering sort of a supportive role there but it was also a way of being able to bring people back quicker to us if they were saying oh, you know they've go some concerns about this one, so we could access that information. But we would, if this person had self harmed then we would have to reassess them.'

21.55 The Independent Investigation Team is concerned that this process could potentially result in Substance Misuse Practitioner 1, an unqualified practitioner, again becoming responsible for a role and function for which she is not qualified and in which she is not supported by the MHIRT clinical governance framework. This is a matter of concern.

21.56 It is a matter of concern to the Independent Investigation Team that, despite the addition of the IDTS Service at HMP Peterborough, there is no clear protocol governing the relationship between the IDTS and the MHIRT. Key aspects of the operational structure are absent. For example, Substance Misuse Practitioner 1's job description does not set out her role and responsibilities in relation to her joint work with IDTS.

21.57 Additionally, the Independent Investigation Team is concerned that many of the practice procedures currently followed are dependent on the presence of a Mental Health Practitioner as part of the IDTS Team. The MHIRT and not IDTS is responsible for assessing the mental health aspects of an individual's presentation. The MHIRT and IDTS are the subject of different clinical governance structures and their roles and responsibilities are different. The Independent Investigation Team is of the view that the close working relationship which has developed between the two services is to be encouraged and represents an element of good practice. However, it is essential that there is clarity of roles, responsibilities and functions. This protocol

requires careful consideration in order to ensure that an individual's substance misuse forms a constituent part of their overall presentation and is not allowed to delay or prevent a full clinical evaluation of their overall mental health needs. The Independent Investigation Team have been advised that CPFT *'will review this working arrangement and will produce a joint working protocol in partnership with the prison's IDTS.'*

21.58 The importance of protocols governing the relationships between the various prison services has previously been brought to the attention of the MHIR Service by HM Inspector of Prisons in relation to the MHIRT's relationship with CARATS (see Paragraph 10.12).

21.59 Key Points

1. Mr A was referred to the MHIRT by CARATS on 23 July 2008.
2. Mr A was seen on two occasions by a substance misuse practitioner working within the MHIRT (14 August 2008 and 8 September 2008).
3. Substance Misuse Practitioner 1 was asked to see Mr A with a view to assessing whether he required care from the MHIRT. As an unqualified individual, this request was not appropriate. In addition, Substance Misuse Practitioner 1's case load was not the subject of formal supervision. This is unacceptable and potentially dangerous practice.
4. The MHIRT had in place a weekly multidisciplinary team meeting at the time of Mr A's care. New referrals could be discussed at this meeting. Mr A's care was not discussed despite two individuals involved in Mr A's 'referral' being present at meetings during this period of his care by MHIRT.
5. At the time when the MHIRT was trying to establish the true nature of its case load due to difficulties with its referral processes and pathways, Mr A's name was omitted from the MHIRT's database. A manual system has now been introduced to capture referral and discharge information.
6. Mr A's psychiatric needs were complex. His needs fell within the eligibility criteria outlined in the MHIRT's Operational Policy dated September 2005. However, his needs did not receive a proper clinical evaluation.
7. Substance misuse can indicate a degree of 'self-medication' by individuals who are experiencing issues relating to a personality disorder. A full clinical evaluation is necessary to reach such a diagnosis and devise an appropriate treatment plan. If a

substance misuse problem is seen in isolation, important diagnostic information may be missed.

8. HMP Peterborough has introduced an IDTS since Mr A's care. This is an element of good practice. The MHIRT and IDTS service operate a joint clinic run by a dual diagnosis nurse working for IDTS and a substance misuse practitioner.
9. The relationship between the IDTS and MHIRT is not the subject of a formal protocol. This is an important control weakness.
10. The Independent Investigation Team is concerned that the individual providing the link between IDTS and MHIRT could remain an unqualified individual in the absence of a formal protocol.

21.60 Additional Learning

1. The Independent Investigation Team is of the view that prompt consideration should be given to a formal protocol being adopted, governing the roles and responsibilities of the IDTS and MHIRT and the individuals involved. This protocol should take into account the clinical governance and care co-ordination responsibilities of MHIRT and IDTS. Any such protocol requires careful consideration in order to ensure that substance misuse is seen as a constituent part of an individual's overall presentation.

22.0 RISK ASSESSMENT

22.1 Risk assessment and management of the propensity for violent behaviour are a crucial aspect of the role of MHIR Services.

22.2 Risk assessment has been defined as the *'probability calculation that a harmful behaviour or event will occur'* and involves an assessment about the frequency of the behaviour/event, its likely impact and who it will affect (Kemshall*, Reviewing Risk: A review of research on the assessment and management of risk and dangerousness: implications for policy and practice in the Probation Service. A report for the Home Office Research and Statistics Directorate. London: Home Office*).

22.3 Commonly used Risk Assessment Tools in the Criminal Justice System

22.4 Care Programme Approach ('CPA')

22.5 CPFT instigated a Care Programme Approach Policy on 20 July 2008 ('the CPA Policy'). This policy states:

> *'1.2 The CPA is the fundamental process used by specialist mental health services for documenting clinical and social care. The CPA supports a holistic and integrated approach to a person's health and social care needs through systematic assessment, care planning and review. The CPA:*
>
> - *Supports the application of minimum standards of clinical care across client groups and specialist services*
> - *Supports integrated mental health care delivery*
> - *Enables the Trust-wide collection of information to meet national, regional and local requirements*
> - *Improves efficiency and avoid duplication of clinical procedures and information collection.*
>
> ***2.0 The Care Programme Approach***
>
> *2.1 The CPA exists to ensure that patients of specialist mental health services - and their carers where relevant - receive comprehensive, well-coordinated care, which is sensitive to their individual needs and has good continuity over time and over settings.*
>
> *It is regarded by the Department of Health as "the framework for care coordination and resource allocation in mental health care" (original emphasis).'*

22.6 Risk management was given a relatively low profile in the CPA policy. Risk assessment is mentioned in the following terms:

> ***'5.0 ASSESSMENT AND REVIEW***
>
> *5.1 All users of mental health services will be assessed using the CPA assessment framework set out in the agreed CPA documentation. This includes an analysis of the person's health and social care needs including the presenting problem, and a risk assessment. There should be a consideration of appropriate services including self directed support.'*

22.7 Substance Misuse Practitioner 1 did not use CPA documentation when she saw Mr A, which does not accord with CPFT policy. Given the complexity of Mr A's presentation, and Substance Misuse Practitioner 1's role, the Independent Investigation Team would question whether Substance Misuse Practitioner 1, acting without supervision, would have been in a position to comply with CPFT CPA policy in any event.

22.8 CPFT has made substantial changes to its CPA framework and processes since 2008. Its efforts have been recognised in a National Award. A particularly interesting innovation is the adoption of the '7C's of care planning' which is an initiative programme being rolled out across the Trust. The 7C's of care planning condense the key elements of the CPA process into easy to understand 'principles' for staff to consider and follow. For example, one element encourages the following:

> *'Is centred on them as an individual, considering all aspects of their individual circumstances and on their immediate and longer-term needs, reflecting their preferences, goals and aspirations.*
> *Focuses on the safety of the person and of others, identifying risks and stating how these will be minimised, managed and reviewed.*
> *Maintains the individual's welfare and promotes their wellbeing taking account of all needs including physical, mental, social, personal relationships, emotional and activity.*
> *Enables individual's to manage their own health, encourages prevention and early detection of ill-health, enabling them to make healthy living choices.'*

22.9 A recommendation in the Internal Report was that *'the management of risk should be in line with the Trust CPA Policy'*, The MHIRT have begun a process which adapts CPFT's approach at Trust level to CPA in the unique environment of a prison. This work is ongoing. See also Paragraph 24.13.

22.10 Offenders Group Reconviction Scale-2

22.11 The Offenders Group Reconviction Scale-2 (OGRS-2) is an actuarial risk assessment tool based on ten criminogenic factors that are considered important in assessing the risk of reconviction. The OGRS-2 provides a probability of general recidivism along with risk classification indicating likelihood of future sexual and violent convictions within two years of release. Although originally designed for prison populations, the OGRS-2 is considered a useful tool for assessing reconviction rates in mentally disordered offenders. It is routinely used by probation services across England and Wales.

22.12 The OGRS-2 uses a number of categories to determine the chance of reconviction within 2 years, including:

- Age at time of sentence;
- Gender;
- Number of youth custodial sentences;
- Current offence category (based upon standard list offences and broken down into 27 detailed offence categories);
- Age at current conviction;
- Age at first conviction;
- History of breach;
- Previous convictions for violent offences; and
- Previous convictions for sexual offences.

22.13 The OGRS-2 is available as a Windows based computer program. The above data are entered into the system and the OGRS calculates a percentage probability of reconviction. This probability score represents the average reconviction rate from a group of offenders who match the individual offender on the factors used in the model.

22.14 The OGRS-2 is a useful actuarial tool in measuring an individual's propensity to be reconvicted of any offence and, most importantly for mental health and forensic services, likelihood of reconviction for violent or sexual offences.

22.15 The OGRS-2 is a simple tool to use and can be used as an aid to assist clinical judgment for clinicians in mental health and forensic mental health settings. It takes approximately 10 minutes to complete and requires very little training as

interpretation of the findings is not required in order to determine future risk. This is in direct comparison to other instruments that employ ‘structured clinical risk judgment’ measures of violence risk such as the Historical, Clinical, Risk Management-20 (HCR-20) which can take in excess of 6 hours to complete and requires the assessor to undergo formal training.

22.16 Historical, Clinical, Risk Management-20

22.17 The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool which provides mental health practitioners with an approach to structured clinical judgment that takes account of a set of risk factors. The clinician gathers qualitative information about the person being assessed guided by the HCR-20. The results are used to make treatment and management decisions.

22.18 The HCR-20 does not allow for a definite prediction of violence. Predictions of violence based on the HCR-20 may be offered using probabilistic statements such as ‘low’, ‘moderate’ or ‘high’ but risk varies over time and according to circumstances. Study of the HCR-20 factors can lead to an understanding of situations and states of being that may dispose a person to violence or help insulate them against it. Consideration of such factors can assist in identifying the type and extent of risk presented by a person and in devising a risk management plan that includes intervention strategies intended to reduce the probability that an individual will demonstrate violence.

22.19 Completion of HCR-20 requires a clinical interview and a file review of a number of aspects of the offenders’ presentation including previous incidents of violence, clinical issues and factors which might be relevant for future violence.

22.20 Offender Assessment System (OASys)

22.21 A further risk assessment tool used in the Prison Service is OASys. OASys is designed to enable a properly trained and qualified individual to:

- Assess how likely an offender is to be re-convicted;
- Identify and classify offending-related needs, including basic personality characteristics and cognitive behavioural problems;
- Assess risk of serious harm, risks to the individual and other risks;
- Assist with management of risk of harm;
- Link the assessment to the supervision or sentence plan;
- Indicate the need for further specialist assessments; and

- Measure change during the period of supervision/sentence.

22.22 OASys comprises a series of computer-based forms on which clinical evaluations are made on a periodic basis. OASys supports the *What Works?* initiative of the Prison and Probation Services by providing metrics by which the characteristics of offenders and their offences can be analysed alongside information on interventions made to the offender, and re-conviction data for offenders, in order to enable refinement to be made to interventions to reduce reoffending by ensuring that interventions are as appropriate and purposeful as possible.

22.23 Risk Assessment tools used in Mr A's care

22.24 In Mr A's case, no actuarial/static risk assessment such as the OGRS-2 had been undertaken nor had a HCR-20 assessment, which incorporates both static and dynamic risk factors. In addition, CPA risk assessment had not been compiled. In Mr A's case, if a HCR-20 or CPA risk assessment had been undertaken then factors within his individual presentation (clinical and risk management factors) could have been evaluated with regard to any increase in his dynamic risk factors. Subsequently an increase in his level of risk could have highlighted the need to review his risk management plan.

22.25 Of particular relevance in Mr A's case would have been any changes leading up to the offence in relation to his clinical items and risk management items. It would appear in Mr A's case that there may have been a change in the following clinical items:

i. lack of insight;

ii. active symptoms of major mental illness;

iii. negative attitudes;

iv. impulsivity;

and the following risk items:

i. exposure to destabilisers (e.g. substances);

ii. non-compliance with remediation attempts;

iii. stress.

22.26 However, to have been able to evaluate this accurately at the time, a qualified member of the MHIRT would have needed to be in direct contact with Mr A in the weeks leading up to the offence.

22.27 During the course of the interviews conducted with MHIR staff it was confirmed that in 2007/8, staff were not trained to undertake HCR-20 assessments. Staff are now trained to perform such assessments. This is an element of good practice and learning which flows from the Internal SUI Report 146/2008.

22.28 The MHIRT have prepared a Draft Operational Policy (see Paragraph 14.9). It states in relation to risk that:

> *'9.3 The overriding aim of the MHIR service is to provide risk management response for prisoners with mental health problems. This includes risk whilst patients are under the direct care of the MHIR service but also projected risk at critical pathway points, such as transfers to other prison teams, discharge via the courts and direct release into the community. Risk may be to self or others.*
>
> *9.4 It is recognised that the assessment of risk is multi-factorial and that eligibility for the service cannot be helpfully defined by diagnostic schema. Crisis in patients with even relatively 'minor' mental health diagnoses can be associated with high risk especially in the prison context, where significant life events are common and magnified. Conversely, some stabilised patients with severe mental illness may present as low risk for periods of time. In such cases, the* nature *as opposed to the* degree *of the disorder may determine whether ongoing specialist care is required in order to maintain stabilisation.'*

22.29 Further, Paragraph 10 of the Draft Operational Policy includes the following guidance for staff:

> *'Following referral the following assessments will take place;*
>
> - *Mental Health Assessment;*
> - *Physical Health check;*
> - *Relevant Risk assessments; Suicide risk assessment / Violence risk assessment (HCR-20)*
> - *Health of the Nation Outcome Scale (HoNOS-secure)*

- *Any other assessments relevant to the prisoners presenting problems and specific to specialist staff who provide that input (ie clinical / forensic psychology / psychotherapy)*

The assessment and background information and the outcome of initial assessments will be discussed by the multidisciplinary team (MDT). A formulation of the prisoners problems will be used as a basis for the plan for that prisoner. This information is documented in the prison mental health service's integrated notes and a summary of the assessment will be provided to the prison's healthcare GP and also entered onto the computerised prison health records (System 1)

- *Initial hypothesis will be agreed;*
- *Key areas of immediate intervention/treatment will be agreed;*
- *Further investigations and assessments needed will be agreed and planned;*
- *Risk management agreed;*
- *Capacity/consent discussed and action agreed;*
- *Initial Care plan will be agreed;*
- *Feedback will be made to the referrer/service user/family/carer;*
- *Identify and plan to address discharge issues where relevant;*
- *All of the above will be recorded in the patient notes.*

The MDT will agree the findings from the assessments formulate and then agree a treatment/intervention plan.

Referrals may also be made to other services following assessment.'

22.30 The Independent Investigation Team were also advised that the MHIRT now meets on a daily basis to review the 'morning sheet' to review any incidents which took place over night and risk supervision group sessions take place regularly.

22.31 The Draft Operational Policy includes the following reference to the Group Risk Supervision:

'

- *Fortnightly sessions focusing specifically on the management of risk.*
- *Using standard tools (HCR-20) and suicide risk assessments, promoting the use of structured clinical judgements, from information gathering through to formulation and development of a risk management plan.*
- *Facilitating a team based approach to assessment and management of risk.*
- *Encouraging effective communication of key risk factors for prisoners under the care of the prisons mental health teams between partner agencies, community services and other prison establishment'.*

22.32 This group is led by a senior clinical psychologist and members of the multidisciplinary team attend this meeting. This meeting represents an element of good practice which was not present at the time of the Deceased's death.

22.33 The Independent Investigation Team was advised that the MHIRT do not have routine access to prisoners OASys scores, either in 2008 or indeed today. A significant number of prisoners at HMP Peterborough have short sentences and therefore the Offender Management Service would not routinely assess them if their sentence was for a period less than 12 months.

22.34 OASys had been introduced in HMP Peterborough in 2008 and in 2011, HM Inspector of Prisons commented in relation to HMP Peterborough that:

> *'Offender management did not have a high profile in the prison but offender assessments (OASys) and sentence plans were up to date for eligible prisoners, although some were late and some needed more in-depth analysis.'*

22.35 The Independent Investigation Team was advised during the course of the investigation that the MHIRT now routinely requests details of new prisoners' OASys scores. However, this requirement was not evidenced in any documentation such as alert clinic pro forma documentation which was provided to the Investigation Team.

22.36 The Independent Investigation Team remains concerned that a level of informality surrounds the Risk Assessment processes adopted by the MHIRT. During the course of the Independent Investigation, the Independent Investigation Team were provided with copies of the minutes of the Risk Assessment and Management Supervision Group. The minutes are well written and clear. They represent an element of good practice attaching to the operation of this important aspect of the MHIRT's clinical governance regime.

22.37 However, the minutes also demonstrate that ongoing work is necessary to ensure that all aspects of the risk management process are captured and are clear, transparent and can be easily understood by all connected with the process. This is particularly important in respect of the interface between the clinical governance and risk management systems operated by the prison and those of the MHIRT, as the following entry taken from the minutes of the Risk Assessment and Management Supervision Group illustrates:

> *'2.0 Feedback / Update from Previous Cases*

Prisoner B – MZ completed risk assessment but unfortunately MB was relocated to the wing before the risk assessment report was put in place and discussed with wing staff (operational decision). The risk assessment caused panic and MB was relocated to healthcare.

Discussed how the risk assessment had been mis-understood and made changes to it which made intentions and advice more explicit and less likely to be misread. Discussed the importance of writing risk reports for lay individuals and not to make assumptions that officers understand what we mean at all times.

Action - MZ to re-write risk assessment with amendments as discussed. Risk management plan to be discussed and presented in ACCT review.'

22.38 The Independent Investigation Team is concerned by the apparent informality which surrounds the use of risk management tools by the MHIRT and its internal mechanisms. Outside the prison environment, it is possible to test the clarity and robustness of procedures and processes by using the analogy of a locum. The test is 'How would a locum know how an aspect of risk management was to be handled?' A further question that can be asked is 'How would a locum know what risk assessment tools were available, the circumstances in which they could be used and the mechanism by which existing information can be accessed?' This analogy is not directly applicable in a prison environment where locums are not a common feature due to issues of security clearance. However, the question may also be posed by replacing a locum with a new member of staff.

22.39 During an interview with the current MHIR Team Leader, the Independent Investigation Team was advised that the processes surrounding the risk management meeting have not been fully recorded in a formal procedure. Whilst CPFT believe that this concern has been addressed through improvements to CPA processes referred to at Paragraph 24.13, the Independent Investigation Team feels that this remains a potential control weakness which mirrors the lack of formality of processes which was a feature of the period during which Mr A had contact with the MHIRT and one which, in the opinion of the Independent Investigation Team, should form part of a centralised control system rather than being a part of differing policies.

22.40 Key Points

1. Risk management and management of the propensity for violent behaviour are a crucial aspect of the role of MHIRTs.

2. There are a number of commonly available risk assessment tools in the criminal justice system including OGRS-2, HCR-20 and OASys.
3. In 2008, the MHIRT staff were not trained in the use of HCR-20. All staff now receive training. This is an element of good practice and learning which flows from the Internal SUI Report 146/2008.
4. Mr A was not the subject of a formal risk assessment by the MHIRT. Given the complexity of his presentation and the information which was available to the MHIRT, this is a cause for concern.
5. A significant amount of investment has been made by CPFT into revising and strengthening its CPA processes. Innovative programmes have been developed to enhance the CPA process. The Independent Investigation Team believe that there would be substantial benefit to these programmes being further adapted for the prison environment.
6. Risk management processes within the MHIRT, including the operation of the newly formed Risk Supervision Group, have not been fully formalised. The Risk Supervision Group is a vehicle which the MHIRT has established to discuss risk assessments and represents an element of good practice. The lack of written processes with regard to the operation of the MHIRT is a matter of concern for the Independent Review Team. Lack of formalised written processes can lead to differences in understanding which in turn can cause weaknesses in clinical governance arrangements and structures. This mirrors the lack of formality of process which was present at the time of the Deceased's death and is a matter of significant concern for the Independent Investigation Team.

22.41 Additional Learning

1. The Independent Investigation Team are of the view that there would be merit in the MHIRT formulating its risk management and CPA processes into one source document in line with the innovative practice models currently being adopted in the CPFT. This would allow greater transparency and scrutiny by the Board of CPFT.
2. The Independent Investigation Team are of the view that where there are a number of policies in operation, concerning key areas such as risk, some being prison policies and some NHS policies, or area of joint practice, there is a need for close liaison and coordination. The Independent Investigation Team are of the view that there would be merit in senior managers from the Prison service and a senior manager in CPFT meeting to review respective policy documents. In addition, there

would be considerable merit in those individuals identifying and reducing their operational components to a single standalone practical guide that is accessible and available to all staff. This would provide a better understanding of processes. Whilst Section 15 of the Draft Operational Policy concerning Quality and an Integrated Governance Framework may go some way towards addressing this, the Independent Review Team do not believe that the Draft Operational Policy is specific enough. The Draft Operational Policy states that the work of the Quality and Integrated Governance Framework is led by the Quality and Healthcare Governance Committee and whilst, *'at a local level, prison mental health teams will be represented at prison run governance meetings…'*, the Independent Investigation Team remains of the view that a specific meeting or indeed a specific time at those governance meetings is required to address this issue.

23.0 INFORMATION MANAGEMENT

23.1 One of the biggest challenges facing practitioners in prison health care is that of access to information. This challenge is illustrated by Mr A's case and directly impacts upon risk assessment and management. A substantial number of organisations may have had involvement in an individual's care and ensuring that information is shared across a variety of organisations can often prove problematic. However, it is essential if risk is to be properly assessed and managed. Mr A's case demonstrates how difficult this can be.

23.2 Mr A's records did not contain any details of his offending profile, previous risk assessments, probation reports etc. They did not contain details of the offence for which he was currently serving his sentence.

23.3 When Mr A was first referred to the MHIRT, Team Leader 2 carried out a number of checks to establish whether Mr A was 'known to services'. The conclusion which Team Leader 2 reached at the time was that he was not known to services. Team Leader 2 was asked about the checks which she undertook to establish this at interview as it is not clear from Mr A's records which checks were made. She stated:

'Team Leader 2:
And I couldn't find anything from when I did check I remember thinking I can't find anything because what I was astounded by when the SUI was being done all these notes appeared.

TC: Yeah.

Team Leader 2:
And I'm thinking so how comes I couldn't get those notes because I rang all these people?

JH: Who did you ring, who did you, who did you contact?

Team Leader 2:
The Learning Disability Team here in the Crossley Centre and his GP.

JH: And his GP?

Team Leader 2:
And I spoke to the Mental Health Assessment Team, and that's where I got that information that and also obviously Ward 5'

23.4 It is extremely disappointing that Team Leader 2 was not able to establish key information, which included her own involvement in Mr A's care as a result of her role

in the Court Diversion Service. Further, in making enquiries of Mr A's GP, Team Leader 2 does not appear to have been alerted to the recommendations made by Consultant Psychiatrist 4 in a letter dated 2 July 2007 in respect of Mr A's on going care which included:

> *'he should have psychiatric follow up for the following reasons:*
> - *Psychological help for his anxiety*
> - *Help with his alcohol use*
> - *Prescription of an antidepressant with anxiolytic properties to help with his anxiety*
> - *Attendance at day centre, e.g. Mosaic Centre for group work for self esteem*
> - *Possibly attendance at Learn Direct or other resources to help build his confidence and bring structure to his day.*
>
> *…… I would be grateful if you could refer him to the Adult Mental Health Services so that a referral to the Mosaic Centre can be made, he can receive psychology input for his anxiety and help with his alcohol use.'*

23.5 Team Leader 2 was very much hampered in her attempts to obtain information about Mr A by the fact that at the time the MHIRT did not have a computer link with CPFT. This link has now been established. The Independent Investigation was pleased to note that progress has been made by the CPFT in this regard. Team Leader 1, the current Team Manager, was asked about information sharing in the prison. She stated:

'Team Leader 1:
We've only just recently got CPFT in the prison so we've been slightly isolated from our colleagues. But we keep all our patient's information within our CPFT restricted, so that colleagues can access if we need to look at what's a care plan needs updating some work needs doing if somebody's away or off sick then we can access. But we also keep paper files because that's all we had at one point. We also use Systm One

KR: Hmm.

JH: Yes.

Team Leader 1:
So that we can share information with Healthcare.

JH: Right.'

23.6 SystmOne is a health database for patients which holds information in relation to their physical and mental health and can be accessed by prison GPs, the MHIRT, dentist, optician and administration etc. It does not hold information regarding the prisoner's index offence, previous offending history, risk assessments, expected release date or any adjudications whilst in prison (such as physical assaults, positive drug tests, rule breaches etc.). In order to obtain this type of information access is required to the prison's computer systems. During the course of the Independent Investigation, the MHIRT advised the Independent Investigation Team that they were able to log into CMS, which brings up details of the prisoners' next of kin, a photograph of the prisoner and any alerts regarding safeguarding, illicit substance misuse or violence.

23.7 In addition to information retained in prison and probation service systems, wing staff also record information in their own files, which are often referred to as 'the Greens'. The prison also keeps important information concerning the behaviour of its inmates in security files. Information in these files covers not only adjudications but also substantiated and unsubstantiated intelligence covering an array of potential topics such as with whom prisoners correspond, what has been found in their incoming or outgoing mail, use of telephones, information passed to them from other prisoners, or any suspicions of selling or trafficking drugs or being involved in gangs or violence. This information is often unable to be disclosed in probation reports as it is unsubstantiated and also risks compromising the security in the prison.

23.8 It was unclear to the Independent Investigation Team as to whether there were formal processes in place to ensure that access to data from key sources such as the Probation Service could be made in a structured and systematic fashion. This is a potential gap in the armoury of tools available to the MHIRT as it deprives them of important risk related information. However, this is a gap which is present in many prisons across the country.

23.9 This can be best illustrated in relation to the HCR-20. Use of the HCR-20 is an element of good practice. The Independent Investigation Team understands that, following the Internal Investigation Report conducted into Mr A's care, a training plan was initiated for clinicians, which is again an element of best practice. However, the success of an HCR-20 risk assessment is affected by the information which is available to those conducting the assessment. Without formal protocols governing information flow, such as that involving the prison service, probation service and MHIRT, there is a danger that an inefficient system exists with each individual applying different processes to access information. This constitutes a drain on

resources and can impinge upon the quality of the outcome if key information is missed.

23.10 This concern also applies to the receipt and use of external information. For example, on 12 November 2007, Mr A's solicitors wrote to HMP Peterborough in the following terms:

> *'…. we understand that the Sentencing Judge directed that a previous Psychiatric Report prepared by Consultant Psychiatrist 3 should be forwarded to the prison so that any issues raised in there may be dealt with.'*

23.11 In Mr A's case a judge recommended that a psychiatric report be brought to the attention of those responsible for Mr A's mental health care. This report was received by the MHIRT but was not considered to be of relevance in his ongoing management. No record of the report appears in the Patient Record. It was retained in the correspondence section of his record. The information in the report could have helped build a picture of Mr A's difficulties but was maintained in a format which was not easily accessible to members of the MHIRT. Team Leader 1 stated in interview that the MHIRT has no system for identifying and recording such information at present and that the report would be dealt with in the same way as any other piece of clinical correspondence.

23.12 It is a matter of concern that the MHIRT has not taken the learning from Mr A's case on this point and evaluated how it gathers and handles information received from the Courts or other external bodies. Potentially the lack of systemic processes through which information flows into and out of the MHIRT suggests a reactive approach to risk assessment, rather than one which actively seeks to obtain information to aid clinical assessment or indeed a full risk profile. This is an important control weakness.

23.13 Key Points

1. The process of information management within prisons can be problematic.
2. Effective risk management depends upon access to information from a variety of sources.
3. At the time of the Deceased's death, the MHIRT was not connected to CPFT's computer systems. This hampered the MHIRT's attempts to establish Mr A's previous medical history with regard to treatment received within CPFT. This link is now in place.

4. The MHIRT now has greater access to the prison's computer system which will assist in the identification of information which is relevant to individual prisoners' care and risk assessment. This is an element of good practice.
5. However, the Independent Investigation Team believes that there remains an unacceptable level of informality in the MHIRT's approach to the flow of information. For example, the MHIRT does not have a protocol or process for the receipt of information concerning a prisoner from the court or the prisoner's solicitors, despite this being highlighted as an issue in relation to the care of Mr A.

23.14 Additional Learning

1. Individuals working in the prison environment have a tendency to work in isolation from other professionals who might have valuable input into a patient's care and treatment plan. In order to deliver the best care and accurately establish risk, it is necessary to have as wide a picture as possible of the patient. This could be partly achieved by reviewing the pathways through which information flows. For example, reviewing the data requested on the alert form and amending consent forms could facilitate the easier flow of information.

24.0 REVIEW OF MHIR SERVICES AT HMP PETERBOROUGH

24.1 In May 2009, a review of the MHIR Service entitled *'Service Review Prison In-Reach Mental Health Team'* was commissioned by the Chief Executive of CPFT following concerns raised by consultant psychiatrists working within the MHIR Services provided by CPFT, involving resourcing issues, governance, clinical risk and safety (the 'Review').

24.2 The Review was conducted by an external assessor, who is a consultant forensic psychiatrist. The purpose of the Review was to assess the capacity and functioning of the MHIR Services provided to prisoners in HMP Littlehey, HMP Whitemoor and HMP Peterborough. The Review considered whether service delivery within the MHIR Services was in accordance with CPFT policies and procedures, National Service Framework (NSF) standards and HM Inspectorate assessment criteria, and was tasked to provide a stock take of the current development of prison MHIR Services with recommendations for service improvement and development. A steering group was set up to oversee and monitor the process.

24.3 The Review made a number of key findings including the following:

- The MHIRTs were set up with resources allocated according to the limited funding made available rather than identified need;
- Staff, whilst dedicated and committed, were not adequately trained; and
- The absence of clear SLA or service specification resulted in each team working independently.

24.4 The Review concluded that a care pathway and service needed to be agreed within a robust governance framework as a priority. The Review made six recommendations, the aim of which were to introduce a strategic framework which would allow the MHIRTs to provide an effective and safe service which met the needs of offenders.

1. *'Mental health needs should be assessed and identified on arrival. It is recommended that consideration be given to integrating primary and secondary mental health care to create a comprehensive pathway with good reception screening. This should be limited to the offender pathway.*
2. *A robust clinical governance structure and forum should be developed that involves all in reach staff as a sub group of the senior management team and a clear process identified that interfaces with the prison and the CPFT clinical governance forum. A yearly clinical governance plan should be devised.*

3. *Revised CPA documentation should be reviewed, agreed and implemented with clear guidance on how it should be used. Care co-ordination should be multidisciplinary.*
4. *The CPA should be audited in line with the rest of CPFT and form part of the yearly clinical governance programme monitored by the senior management team.*
5. *The Prison In Reach Service should be developed as one whole service with core standardised systems and processes monitored through one management team. Lines of operational management should be clarified with the role and responsibilities of team leaders and the team manager being clearly differentiated.*
6. *The Trust should work with commissioners to develop a robust SLA. The current level of resources available should be reviewed and a clear service specification should then be developed. A dashboard of quality indicators and agreed targets that can be monitored should also be developed.'*

24.5 The Review concluded that the recommendations which it proposed and action taken should be reviewed in 6-12 months. CPFT have completed a significant amount of work in order to implement the recommendations made in the Review. This has involved a substantial investment in resources at a number of levels. The clinical governance regime of the MHIRT has been significantly strengthened as a result. This represents an important element of good practice.

24.6 The Independent Investigation Team was advised by Director of Adult Specialist Services 1 on 3 February 2012 that the Review would be followed up by an external advisor in April 2012. A delay in conducting a second review had been occasioned as a result of the advisor's commitments. The Re-Review of Prison In Reach Mental Health Services (the 'Follow Up Review') was eventually conducted on 26 and 27 July 2012 and its conclusions were summarised in a report which has been produced to the Independent Investigation Team.

24.7 The Terms of Reference for the Follow Up Review were as follows:

'(1) To assess whether or not the recommendations in the original report were implemented.

(2) To review the current provision of service and make recommendations for the future, ensuring best practice is achieved within available resources.

(3) To review the care pathways, from reception to release or hospital transfer.

(4) To present the above in a way which could support the PCT's review of the SLA.'

24.8 The Follow Up Review considered that:

'In general terms the recommendations made in the original report have been implemented and significant progress has been made across most of the areas identified as needing development. Given the difficult circumstances prevailing in the Trust in the last few months, the staff and Specialist Services managers should therefore be congratulated. Of course, there is still room for improvement.'

24.9 The Follow Up Review made the following comments in relation to mental health screening which had been the subject of previous criticism and the impact of the Alert Clinics:

'Despite the best efforts of the inreach teams, there remain problems with the mental health screening undertaken at Reception by Healthcare staff in all the prisons in terms of its reliability and validity. Attempts have been made to improve the quality of interviewing practice in Peterborough, but there have been difficulties with the prison making these staff available.
There has been a more successful initiative to increase referrals from the Wings and self-referrals using an 'Alert' system in Peterborough and this may have compensated somewhat for flaws in the Reception screening.'

24.10 In relation to clinical governance which had been a significant concern in the Review, the Follow Up Review stated:

'There has been good progress in developing the Trust's clinical governance arrangements across all the teams [N.B. the meetings set up by WS-E need to be restarted as soon as possible]. There is still work to be done in terms of managing the interface between the Trust's governance processes and those of the individual prisons.'

24.11 The Follow Up Review went on to recommend:

'New Recommendation: Further work needs to be done in all the prisons to strengthen the links between the governance systems of the Trust and those of the prison. This applies particularly to input into the Sentence Planning process.

In addition to the regular reviews in weekly team meetings and as part of CPA, all the teams had introduced six monthly, or annual, total case reviews ('spring

cleaning'). These had proved very beneficial and the general view seemed to be that they should be instituted as a matter of routine practice.

New Recommendation: Annual full team caseload reviews should be instituted as a matter of routine practice.'

24.12 The Follow Up Review also commented that:

'We were also shown a number of examples of new CPFT policies (e.g. CPA, Incident Reporting, Managerial and Clinical Supervision) and were assured that these policies have now been implemented. In the time available we could not verify these claims, but found no evidence to the contrary.'

24.13 The Review had also commented adversely upon MHIRT's CPA processes. The Follow Up Review made the following points:

'Following the attention given to the Trust's CPA processes by CQC earlier in the year, there has been a considerable emphasis on recording and auditing CPA information. This led several staff - sometimes a little reluctantly - to acknowledge that written recording of CPA planning had definitely improved. From what we could see through a limited inspection of selected casenotes, this did seem to be the case.

There are still some problems regarding the applicability of the detail of the revised CPA which is being introduced into the general adult services in the Trust. This is probably inevitable and the senior managers (particularly the Team Manager) will just have to continue to try to 'tweak' the documents to make them as relevant as possible. Despite these problems, a much more 'corporate' approach to care planning had been established across all the inreach teams and there was generally a much more positive attitude towards CPA.'

24.14 The Follow Up Review made the following recommendations:

'New Recommendation: Senior managers in the Division need to continue their discussions with the Trust to improve the applicability of the general CPA documentation for adult services in the context of the prison.'

24.15 A recommendation that was made in the Review related to developing the MHIRT as a single standardised entry across the three prisons. This stated:

'Lines of operational management should be clarified with the role and responsibilities of team leaders and the team manager being clearly differentiated.'

24.16 Encouragingly, the Follow Up Review stated:

'The successful breaking down of the 'silos' between teams that were very evident in the last report seemed to be related to a number of factors. First, the appointment of a single team manager (WS-E) who knew most of the staff well and who had exercised very effective leadership, bringing the teams together into a much more coherent whole. This has been facilitated by a number of joint meetings (led by WS-E) to discuss CPA and other issues and by the judicious movement of staff around the teams. This seems to have broken up some fixed practices and made the three teams more open, while at the same time more aware of their identity in a single service.

The introduction of teams + clinical leads has also produced effective leadership 'on the ground'.'

24.17 The Follow Up Review team considered that an SLA be developed. The Follow Up Review observed that:

'The current SLA which was written in May 2010 is inaccurate and out-of-date. The positive developments described above now need to be brought together in a single SLA which accurately reflects current practice. We did not detect a great enthusiasm for this task on the part of the commissioner (JE) but we think it is still worthwhile as the new commissioning arrangements may be slow to be implemented and, in the meantime, it could prove useful in future negotiations with the prisons.

New Recommendation: A new SLA is now required to reflect current practice and resources. Senior managers in the Division should therefore re-open discussions with the relevant existing commissioner(s) regarding the production of such a document.'

24.18 Comments in relation to current provision of services by MHIRT

24.19 The second Objective of the Follow Up Review was to:

'To review the current provision of service and make recommendations for the future, ensuring best practice is achieved within available resources.'

24.20 The Follow Up Review Team noted that:

'5.1 In general, resources for the teams are very limited and they are doing an excellent job to meet a diverse range of needs and maintain good standards of practice.

...

However, there were two specific areas where we felt that the resources available were not addressing urgent and important needs effectively. These were: (a) with regard to the needs of prisoners with certain

specific health and social needs; and (b) with regard to medical/psychiatric input.

5.3 ***Prisoners with specific health and social care needs –*** *Within the prison population there are a number of groups of prisoners with multiple needs who require specific expertise in order to provide a good standard of care. These include those with:*

- *mild/moderate learning disabilities, often in combination with mental health problems and personality difficulties.*
- *Complex personality disorders*

...

…in the case of the in-reach teams in CPFT, a number of the existing staff do have the relevant specialist skills (e.g. in working with people with learning disabilities, or those on the autistic spectrum) they simply had insufficient capacity to be able to use them in current arrangements. A relatively small increase in general resources might therefore release some time for these staff to bring their specialist skills to bear on these complex problems.'

24.21 The Follow Up Review then went on to consider the medical/psychiatric input available to the MHIRT. They stated:

'We were frankly shocked by the lack of medical resource available to the teams. Consultant Psychiatrist 8 provides just one day a week at Whitemoor and Consultant Psychiatrist 9 covers both Peterborough and Littlehey with three sessions. There is no cover for sickness or absence. This is not acceptable.

It was quite clear that staff highly valued the contribution made by these doctors to the work of the teams. They were regarded unanimously as highly competent, hard-working, dedicated and flexible.

While the teams have responded intelligently and creatively to these restrictions in medical time and have found ways of maximising the contribution that their medical colleagues can make by ensuring that they are not required to undertake any extra activities apart from seeing patients. This is still not satisfactory.

Psychiatrists in prison have many potential roles – assessing new patients, reviewing medication, monitoring physical health, initiating referrals to hospital, liaising with the courts and MoJ, etc. But they can also make an important contribution in terms of leadership and support in relation to the team's priorities and key areas for development. With the current levels of medical input, these latter functions are simply not possible.'

24.22 The Follow Up Review made the following recommendation:

'New Recommendation: Senior managers from the Division urgently consider how they can increase medical input to the inreach teams. We suggest the following guidelines as minimum acceptable levels:

- ***...***
- ***Peterborough – 3-4 sessions'***.

24.23 It is a matter of concern to the Independent Investigation Team that the access which the MHIR Service has to a Consultant Psychiatrist has been reduced since the time at which Mr A received care despite the findings of the Review which stated that '*there is wide variation in mental health staffing levels across the prisons but the staffing levels at Peterborough are particularly low against comparable prisons*.'

24.24 In addition, it was stated that:

> *'The Department of Health's guidance (DOH 2002) on the size and caseloads of community mental health teams suggests that a typical community mental health team with a caseload of 350 service users (only half of which are complex cases),would consist of 3-4 community psychiatric nurses, 2-3 social workers, at least 1clinical psychologist, a support worker, an administrator, and two full time doctors including a consultant psychiatrist - in total between 12 and 16 WTE staff. In relation to prison in-reach teams, the Royal College advises that psychiatric staffing for a Category B local remand prison of 500 places should be 0.5 WTE consultant and 0.5 WTE non-consultant grade, plus 0.2 WTE addiction specialist sessions and additional psychotherapy input.'*
>
> *'…..The studies carried out by the Sainsbury centre 'Short changed' 2008 conclude that the resources currently available for mental health care in prisons are only about a third of the amount required to deliver an equivalent in the community. The findings support this and in Peterborough are even below a third.'*

24.25 At the time of the Deceased's death, the MHIRT did not have access to a consultant psychiatrist at levels recommended by a number of professional bodies such as the Royal College of Psychiatrists. These recommendations are based upon numbers within the prison population and not the case load of individual MHIRTs. The population of HMP Peterborough has not changed significantly since 2007. The Independent Investigation Team shares the views expressed in the Follow Up Review that the lack of medical resources at HMP Peterborough needs urgent consideration. See also Paragraph 24.21.

24.26 The Follow Up Review considered the issue of record keeping in relation to resource use and best practice. The Follow Up Review noted:

'Currently most of the clinical records of the inreach teams are kept in paper form. This has some advantages in terms of flexibility and security of personal information. However, accessing relevant information is often difficult and time-consuming and paper records do not easily support audit.
…
One of the prisons (Littlehey) makes extensive use of 'SystmOne' and simply prints out this information into their clinical records. Other teams make less use of it, mainly for reasons of data confidentiality. When they do use it they tend to input the minimum of information (extracted from the paper records).

There are thus two parallel sets of records in existence in all of the prisons and it is unclear which of these constitutes the primary record. This is not satisfactory both from a governance point of view and in terms of the accessibility of key clinical information (e.g. a prisoner's current risk status).

Therefore there needs to be clear guidance regarding what information to enter into 'SystmOne' and what should remain in paper records and this may require local discussions with the prison managers in order to address concerns about confidentiality and security of information. This also needs to be consistent across all three prisons. The advantages of 'SystmOne' in terms of audit must also not be overlooked.'

24.27 The Independent Investigation Team would concur with this concern as it mirrors an issue which arose in Mr A's case, notably access to a previous psychiatric report (see Paragraph 23.11).

24.28 The Follow Up Review also noted the benefits available from the planned introduction of the RIO electronic record system over the continued use of paper records. However, it noted that there was a possibility that this would merely add another set of records rather than bringing information about a patient together.

24.29 In view of the problems experienced by the MHIRT as demonstrated in Mr A's care, it is clear that CPFT were right to commission an external review and it forms an element of good practice. The existence of a Follow Up Review, albeit somewhat delayed, demonstrates an ongoing focus on developing the MHIR Service and is a fine example of good practice. Such regular reviews are an important tool for facilitating Board oversight and strategic planning.

24.30 Key Points

1. An external Review (the 'Review') of the MHIRT was conducted in May 2009.
2. The Review was detailed and made recommendations which were designed to significantly strengthen clinical governance arrangements within the MHIRT.

Following the Review, CPFT made a substantial investment in the MHIRT which is an element of good practice.

3. A Follow Up Review was carried out in July 2012. This noted that good progress had been made in relation to many of the issues raised by the Review but that some concerns remained, particularly in relation to access to a consultant psychiatrist.
4. For example, the Independent Investigation Team have noted at Paragraph 24.25 that the level of access to a consultant psychiatrist available to the MHIRT in 2008 did not comply with the National Guidelines at that period. Despite this, the level of access available appears to have been reduced. This was flagged by the Follow Up Review as a major concern.

25.0 CARE DELIVERY ISSUES IDENTIFIED PRIOR TO MR A'S CARE

25.1 There is an email trail showing that a number of systemic problems which were a feature of the care afforded to Mr A had been brought to the attention of the management team responsible for the MHIRT at HMP Peterborough prior to the Deceased's death.

25.2 In an email dated 16 July 2008 the then Medical Director, Medical Director 1, wrote to Director of Adult Specialist Services 1, the Director of Adult and Specialist Services following a conversation with Consultant Psychiatrist 5 raising the following concerns:

> *'There certainly seem to be some issues around clinical skills in the Peterborough team and this will require active managerial support to improve the quality of the service. She also told me that the notes used in the prisons are not actually part of the Trust's record systems so that she would not know if a patient in prison was already under our care elsewhere and likewise other services would not be able to access psychiatric records made in the prison. It sounds as if this needs to be clarified. The notes made by our staff should be available to other professionals in the Trust irrespective of the setting.'*

25.3 In an email dated 22 July 2008 addressed to the Team Manager of the MHIRT at the time, Consultant Psychiatrist 5 set out some observations which she had regarding the management of resources within the MHIRT and the support of its team members.

25.4 A significant concern for Consultant Psychiatrist 5 was lack of consultant time. However she also expressed the following concerns about staff training and the role of junior staff members:

> *'b) could we think about what may be needed to protect junior staff such as unqualified nurses and assistant psychologists, and the patients cared for by them, in terms of induction around risk management?*
>
> *We are exposing very inexperienced and / or junior staff to situations where they may have to take much more responsibility than in standard community settings, for much more complex cases. Basics may need to include specifying that an adequate clinical review (unless clearly negotiated with a suitably qualified clinician and with a documented rationale) consists of e.g. face to face interview and not just a telephone call to the wings to ask officers how a patient is doing, especially if active risk such as suicide risk has been identified.'*
>
> *'…Also, are there are clear enough processes for ensuring that when work is allocated to junior staff, it has been established that they understand the potential risks, including more subtle risks such as boundary infractions. Or that*

the level of risk is suitable for their level of experience and or appropriate supervision is in place to compensate.'

25.5 Further, in an email dated 7 August 2008 written by Consultant Psychiatrist 5 to the MHIRT Manager at the time, key issues such as problems with the filing system operated by the MHIRT and difficulties in relation to the tracking of referrals were raised in the following terms:

'Whilst there are needs across the service as a whole, the greatest need for organisation is at Peterborough. There were no obvious systems in place for visiting doctors. An appointments diary was only started at my request. Documents are not prepared in readiness for clinics. In Reach notes are sometimes pulled for me but not reliably so. Finding notes myself can be diffcult as the notes filing system is chaotic and contains numerous old case notes. Appointments are not always confirmed. Patients are not reliably reviewed by the team in between my appointments or reviews are done very superficially. With the exception of Psychology assessments, the screening assessments carried out by the team are mostly unstructured and very superficial. ……

….lack of clinic preparation and base line assessment reduces the number of patients I can see. I am not able to reliably make dual entries in In Reach and the IMR at Peterborough due to the systems problems and unpredictable time constraints that arise from this.

….. Also, Team meetings are slowly improving with the intensive help that you have provided and the introduction of a more structured format, but I am not yet confident that we have a safe and auditable system for tracking referrals, or ensuring that they are all reported via the team meeting. I have observed 'referrals' coming in as brief jots on hand written scraps of paper and not being clearly processed in a standardised, single point of entry procedure. Without a reliable mechanism for chanelling important clinical information through team forums, I cannot provide effective oversight of the clinical service. (And MDT process in general is less robust).

……I would be happy to contribute to teaching and skilling up the teams.'

25.6 Attempts made by the MHIRT to establish and identify its case load accurately are referred to at Paragraph 21.23.

25.7 A draft letter written by Consultant Psychiatrist 5 and sent to WSE for comment on 26 August 2008 attempts to deal with the allocation of resources. The letter, which was intended to be shared with the MHIRT, includes the following:

'Short daily team meeting at 9.00 am for 10 – 15 minutes to prioritise the day's work. In particular, to work out how team members with the most urgent clinical tasks can be supported. Eg. If other team members can support them with the

work, or take on other tasks to enable them to focus on the main task in hand. Accordingly, less important work can be postponed or cancelled to make room in the overall team caseload. The daily team meeting is also an opportunity for junior team members to flag up any specific supervision / help arising from cases seen the previous day.'

25.8 On 17 September 2008, Consultant Psychologist 1, a psychologist working with the MHIRT, sent an email to Consultant Psychiatrist 5 in the following terms:

'*Just to let you knw[sic], I had a chat with Substance Misuse Practitioner 1 this morning about her substance misuse caseload, especially those with major mental illnesses. Substance Misuse Practitioner 1 said that she was hugely relived that it came up at the meeting. Substance Misuse Practitioner 1 knows her drug stuff extremely well but is not shy of admitting that where there is a major mental health component she needs more supports which is not forthcoming!!! This was partly the reason we introduced a section in the team meeting structure for Substance Misuse Practitioner 1 to put her bits in, this was to give her confidence in bringing issues, I am sure that we can amalgamate this in with the referrals section once Substance Misuse Practitioner 1's confidence grows.*

I think part of the problem is that where there is a substance misuse problem this is seen as the main presenting problem and the mental health problems get seen as secondary to drug misuse. We may need to work on the alternative hypothesis that patients may also use substances as a result of serious mental disorder!!!'

25.9 In an email to the former Clinical Director, Clinical Director 1, dated 29 August 2008, Consultant Psychiatrist 5 made the following observations about the MHIRT:

'I expected that the leaderless teams would have some issues but there are more than might be imagined at Peterborough. I am told that the previous visiting Psychiatrist was not attending for months and that no action was taken about this. On closer inspection, there are also other issues, such as submission of over inflated caseload reports by a factor of four…..

There appear to be historical management issues which affect the efficiency and safety of the whole MHIR service, and impact on my effectiveness. We are in the middle of a management transition, and are waiting for two new managers to take up post. It may take some time before systems are running effectively'.

25.10 Throughout the course of the Independent investigation, CPFT was very honest and open with the Independent Investigation Team. Various witnesses explained that prior to Mr A's care, governance systems utilised by the MHIRT were not fit for purpose. On closer inspection, the Independent Investigation Team has found this

not to be entirely accurate. It appears that some aspects of clinical governance such as team meetings were in fact in place but were simply not utilised or were not utilised properly.

25.11 The Board of CPFT and senior management were advised of the difficulties in the MHIRT by members of the team prior to Mr A's care. Along with patients, staff are in a good position to detect when there are service delivery problems and what might be the cause of those difficulties.

25.12 The Independent Investigation Team acknowledges that lack of management continuity during the period around the Deceased's death had a significant impact upon the quality of leadership afforded to the MHIRT, which in turn had a detrimental impact upon the quality of care delivered. Lack of continuity deprives those who are directly responsible for delivering care of the benefit of consistent and properly informed advice, particularly in areas where they themselves may have limited knowledge or experience. There is little doubt that this lack of continuity was a factor in the development of the MHIRT's governance systems.

25.13 The Board of CPFT did ultimately instigate a review entitled Service Review Prison In Reach Mental Health Team (the 'Review') of the MHIRT in May 2009, following the concerns raised by two of its consultant psychiatrists. However, given the nature and gravity of the concerns raised prior to the Deceased's death, the Independent Investigation Team believes that the Review could have been performed at an earlier stage in order to maximise patient safety. In addition, interim measures could have been put in place with a view to improving patient safety prior to the Review commencing.

25.14 Key Points

1. A number of the systemic problems which were a feature of the care afforded to Mr A had been brought to the attention of the management team responsible for the MHIRT at HMP Peterborough prior to BM's death.
2. Whilst the Board of CPFT did ultimately instigate the Review of the MHIRT in May 2009, following concerns raised by members of its staff, the Independent Investigation Team believes that action could have been taken at an earlier stage to maximise patient safety and interim measures should have been considered.

26.0 INTERNAL INVESTIGATION

26.1 In February 2008, the National Patient Safety Association published Good Practice Guidance ('the Guidance') in relation to the investigation of serious patient safety incidents in mental health services. The Guidance aimed to help ensure a consistent approach to investigations across the health service and to raise standards.

26.2 The Guidance envisaged a three stage process in relation to the investigation of serious patient safety incidents. Firstly, there would be an initial service management review, then an internal NHS Mental Health Trust Investigation. There would then be an external investigation.

26.3 Initial service management review undertaken by CPFT (the 'Initial Report')

26.4 The Guidance states:

'When any serious incident occurs, an initial internal service management review should take place within 72 hours. The aim of the review is to take any immediate clinical or managerial action necessary to ensure safety, such as ligature point removal, or make any necessary urgent changes to policies or procedures.

'Action may also be required in relation to staff, other individuals or organisations. Potential evidence, such as clinical notes or medical equipment, should be secured in preparation for more detailed investigation. Early contact with carers and families is important.

'Identify witnesses, including staff, and other service users, to ensure they receive support.'

26.5 On 17 September 2008, Consultant Psychiatrist 5 and Team Manager 1 had a telephone conversation concerning the incident involving Mr A. Consultant Psychiatrist 5 maintained a note of this conversation recorded in an email, which has been provided to the Independent Investigation Team. Consultant Psychiatrist 5 did not share this note with Team Manager 1. The note states:

' T/C to Team Manager 1
Re: Mr A
Mr B
Alleged murder
Handed over file information, lack of risk assessments generally in the majority of files, loose practices in closing files, OASys info on Mr B, false impression that Mr B was still under In Reach, info on SA media profile.

Discussed ambiguous role of Substance Misuse Practitioner 1 drug worker. Asked if she is part of In Reach team or drug services as she seems to work in complete isolation and be treated as a separate part of the service. Not sure who is supposed to be providing medical input to her patients or identifying those with complex mental health needs that should be referred over to MHIR. Several cases of psychosis emerged so far. ML Agreed to clarify.
He will liaise with NW regarding appropriate level of reporting and whether SUI appropriate at this stage. He will arrange for DATIX report to be filed by the team and he will attend next week's team meeting. he agrees practice around closure of cases needs tightening up.'

26.6 The Initial Report was dated 24 September 2008. It was not compiled using a formal Trust Report Pro Forma nor indeed was any other investigation template used. The Initial Report was not signed. It was compiled by Team Manager 1, who was at the time Team Manager for Substance Misuse Services in Cambridgeshire and Acting Team Manager for the Cambridge Peterborough In-Reach Services.

26.7 The Initial Report was compiled from a review of Mr A's case records and discussions with members of the In-Reach Team.

26.8 The Initial Report identified that an incident had taken place at Peterborough Prison and involved the death of a prison inmate. It noted that 20 inmates had been charged in connection with the death, of which two had had contact with the MHIRT. By the time that the Initial Report had been completed, all of the prisoners involved in the incident had been transferred to other prisons. Information regarding those prisoners had been passed to the prisons which had received them.

26.9 The Initial Report stated in relation to Mr A that:

'One of our transfers was to Whitemoor and so this inmate may again be cared for by the Trust.'

26.10 In relation to Mr A, the Initial Report identified the following:

'Was seen by members of the team on three occasions between 15/10/07 and 08/09/08. He had been seen in the community locally by a psychiatrist before he was in custody and had been treated at that time with anti-psychotic and mood stabilising medication. The notes record some feelings of paranoia. and the risk assessment records some self harm in the past. Most of the input recorded however relates to support for a drug dependency problem and he was not reviewed by a doctor for mental health needs whilst in the prison. It would appear there were no particular concerns for his mental health nor of risk to others.'

26.11 In relation to the other In Reach service user, Mr B, the Initial Report stated:

> *'Has had input over a longer period of time: saw 2 different assistant psychologists in The In-Reach team and was considered to be a complex case. Was seen up until 2007 and then case was closed. Was seen again in Jan 08 after which it is not clear whether or not he was a current client, thought there was little direct involvement. His index offence was for violence towards another.'*

26.12 The Initial Report made the following conclusions:

> *'There is a possibility that either of these men may be tried for offences related to murder. This first look at the information held by the Trust would suggest that their contact with the In-Reach team would have little bearing on these matters - but a much fuller investigation would be needed to draw any firm conclusions. The review of the case notes does suggest that the pathways in the team are not clear, in particular there is no consistent recording of whether a client is current or has been discharged. This lack of clarity could cause problems in many respects - not least in this particular incident should a more detailed investigation and/or court case ensue. The team are becoming more aware of this and other issues relating to their practice. A fuller review of the case notes at some point in time may help them in this regard.'*

26.13 Whilst the Initial Report was not compiled within the 72 hour period envisaged by the Guidance, it does contain some elements of good practice. For example, it was recognised that a more in depth investigation was necessary in order to establish whether the contact which the MHIR Service had with the two service users who had been charged with an offence was relevant to the death of the Deceased. The Initial Report identified the fact that two MHIRT service users were involved in the events leading up to the Deceased's death. In addition, the Initial Report identified the fact that pathways within the MHIRT were unclear and the difficulties in identifying whether a service user was in receipt of care from the Team.

26.14 The Initial Report recommended a review of the case notes in order to help the MHIRT develop areas of its practice, a recommendation which embodies the ethos of improving the quality of patient care and promoting patient safety by harnessing learning when something goes wrong.

26.15 Trust Policy

26.16 In September 2008, CPFT implemented a policy entitled 'Incident and Near Miss Reporting Policy and Serious Untoward Incident Procedure'.

26.17 The following definitions are used in the policy:

'Incident
An incident is an unplanned event which resulted in actual or potential harm to patients, service users, staff, visitors, volunteers, contractors on Trust premises. The definition also encompasses incidents in clinical and non-clinical settings.

Serious untoward incident
The Trust uses the Strategic Health Authority definition of serious untoward incident as any incident on an NHS site, or elsewhere, whilst in NHS-funded or NHS regulated care which may cause or has caused death (including suicide) or serious injury or was life-threatening or created a serious disruption to the normal running of the Trust.

Incident Reporting
Whenever there is an incident in Trust premises or arising from a Trust activity outside Trust premises, it is the responsibility of the person who was directly affected by the incident to report it. Where the affected person is not a member of staff or is a member of staff but incapable of reporting, the person who observed the incident or was first notified is responsible for reporting.

Where a team observed an incident, it is the responsibility of the ward manager/team leader to ensure that someone has reported the incident by the end of the shift.

Incidents are reported on the Trust web based incident reporting system. In exceptional circumstances, where staff cannot access a computer, paper forms are available. Ward Managers/Team leaders are responsible for ensuring that all staff are aware of how to report incidents.'

26.18 In an email sent by Consultant Psychiatrist 5 to Team Manager 1 on 2 October 2008, the issue of whether a local incident report had been generated in respect of the Deceased's death was raised by Consultant Psychiatrist 5. It was pointed out by Consultant Psychiatrist 5 that a DATIX feedback report had not at that stage been received by Consultant Psychiatrist 5.

26.19 On 21 January 2009, Consultant Psychiatrist 5 advised the management team at CPFT, including the Director of Adult Services, that Mr A and Mr B had had their charge of murder reduced to manslaughter because the victim had died of a suspected heart attack during the assault. They reaffirmed their view that the cases should be treated as SUIs and stated:

'One of the patients was receiving active treatment by the unqualified drug worker, without much supervision. I was told the other case had been closed but review of the file did not confirm this – a referral had simply not been clearly progressed…

May I leave the process issues with you?'

26.20 On 6 February 2009, Consultant Psychiatrist 5 and Consultant Psychiatrist 7 wrote formally to the then Director of Adult Services at CPFT in the following terms in relation to the care of Mr A and Mr B:

'We understand that two of those allegedly involved in the incident were patients of the mental health in-reach team. If this is confirmed to be the case, we assume that the NHS response should be the same as would apply in other cases of homicide committed by a person who has been under the care of specialist mental health services.

We are also aware of other serious incidents in the prisons…

We believe that these and other incidents raise questions about the safety, sufficiency and clinical governance of the Trust's current provision of mental health care to Cambridgeshire's prisons. We advise that an urgent review of this issue is undertaken.'

26.21 Such was Consultant Psychiatrist 5 and Consultant Psychiatrist 7's level of concern about the investigation of serious safety incidents in HMP Peterborough that, in advance of a meeting which was convened by CPFT to discuss the issues raised in Consultant Psychiatrist 5 and Consultant Psychiatrist 7's letter dated 6 February 2009, they prepared a comprehensive briefing paper.

26.22 The paper stated in relation to the death of the Deceased that:

'At HMP Peterborough on 11 September 2008 a prisoner (the Deceased) died following an assault. Several prisoners have been charged with manslaughter. We understand that the suspects were subsequently transferred out of Peterborough, and it then emerged that two of them had been in-reach team cases. One was an open case, being seen by an unqualified nurse, and most recently on 8 September. The other, who had a history of self-harm, had not actually been seen by a team member but had been the subject of telephone advice in January 2008 and a telephone enquiry on 1 September 2008. Following the death the question of what mental health care was being received by any of the alleged perpetrators does not appear to have been clarified, nor was the death reported as an SUI at the time so as to ensure that, if appropriate, the Trust could conduct an internal review and consideration be

given to whether there should be an independent homicide inquiry in due course'.

26.23 The paper went on to recommend:

'an examination of clinical governance arrangements for our prison mental health services, particularly in relation to recording and reviewing serious untoward events.'

26.24 On 17 February 2009, Medical Director 1 sent an email in the following terms to Consultant Psychiatrist 5:

'I am writing to acknowledge your letter about patient safety in our prisons…..
Both CPFT CEO 2 and I are very concerned about these issues and I think that on Director of Adult Specialist Services 1's return we will need to think about the most appropriate response. We certainly agree that this is an urgent matter, though obviously there are a lot of facts which I am not aware of at the moment. For example, was the prisoner who died in contact with our services? And, given that the death was in September, did we report it as an untoward incident at the time? Similarly, were the other incidents reported too?
I imagine that an internal discussion will be required first but there are likely to be issues that require the input of commissioners and the prison authorities as well.
Thank you for bringing these issues to our attention. I hope that you will be able to help us to improve matters'.

26.25 Consultant Psychiatrist 5 responded later on 17 February 2009 to that email as follows:

'I have asked for all of the incidents to be reported but am not sure how many were, as I have not received any automatic Datix e-alerts. Paper reports may have been submitted instead. If so, I have not been copied into the latter.

The victim of the alleged homicide was a prisoner, but not known to In Reach. Team Manager 1 was first to be informed ….
…..As regards current work on service effectiveness, systems and clinical governance, F, SS and I met last month to start formulating a strategy now that they have had a brief chance to scope the task. There is a lot to be done.

Clinical governance is the main agenda item on this month's In Reach management meeting agenda. There is, in essence, little infrastructure in place and we will need to start with basics.'

26.26 A meeting took place on 7 April 2009. Consultant Psychiatrist 5 and Consultant Psychiatrist 7 prepared a Briefing Note entitled 'Serious Patient Safety Incidents in Cambridgeshire Prisons' in advance of the meeting. The concerns outlined by Consultant Psychiatrist 5 and Consultant Psychiatrist 7 in summary in the Briefing Note were as follows:

1. *'CPFT prison in-reach staffing levels, especially at Peterborough, are significantly below local need estimates, norms suggested by external bodies, and comparator prisons.*
2. *Health Needs Assessment and Prison Inspectorate reports highlight significant deficiencies in the primary health care context in which mental health in-reach teams work; inadequate clinical governance; lack of primary mental health services, day care and 24 hour/crisis cover; and failure to meet requests for reports for the Parole Board.*
3. *Grave patient safety incidents concerning in-reach team cases may have occurred without appropriate notification to, and review by, CPFT. There is a particular need to implement timely and effective recording, liaison and reviewing arrangements for serious incidents (including near misses) relating to mental health that enable joint tracking and integrated multi-agency learning. More generally, we believe the cases noted above raise questions about the safety, sufficiency and clinical governance of CPFT's current provision of mental health care to Cambridgeshire's prisons. There are both patient safety and organisational risks that are difficult to manage. This is also a context in which efforts by individual clinicians to implement higher practice standards are liable to produce conflict, exhaustion and despair.'*

26.27 Consultant Psychiatrist 5 and Consultant Psychiatrist 7 produced a further Briefing Note on 12 April 2009 which put forward a number of additional suggestions for interim measures within existing resources.

26.28 On 18 July 2009 Consultant Psychiatrist 5 wrote an email to Medical Director 1, titled '*Unprogressed serious patient safety issues*'. This email read as follows:

> *'When we met on monday 6th July I shared with you my concern that no action was being taken with regard to the outstanding serious patient safety incidents. You indicated that you thought that the review would be progressing these issues, and that I should be reassured by this.*
> *However, since then, it has been made explicit at a public meeting that the review is not involving itself in any operational matters. It was clarified that it is a*

purely strategic instrument and that all operational business should continue as usual. This includes the progression of outstanding SUIs. I understand that this has been made clear to the operational managers.
It would appear therefore that you may have been misinformed on the issue of who is, or who is not, reporting or investigating the SUIs.
As you know, I have expressed to you my perception that I have been subject to negative briefings because of issues I have raised. It would greatly help to depersonalise matters if I could have your help to clarify these matters. I would therefore be most grateful, if it is possible, for you to now raise the unprogressed SUIs with the operational managers.'

26.29 On 2 August 2009 Consultant Psychiatrist 5 emailed Medical Director 1. She wrote:

'With regard to the homicide from September 2008, for which two patients known to In Reach are awaiting trial for manslaughter, the acting senior manager stated that he was unaware that this should now be progressed as a SUI. He stated that he was still working under old instructions not to proceed with it given to him when he was acting team manager for in Reach in September 2008.
I was not made aware of these instructions at the time, despite explicitly asking him and others about the progression of this SUI. I simply never received any responses. As you know, the unprogressed homicide featured in the subsequent correspondence and paper by Consultant Psychiatrist 7 and I, and the discussions that led to the review. I also forwarded other relevant data to Director of Adult Specialist Services 1 around that time. There were several opportunities for the apparent decision not to progress this SUI to be acknowledged during the processes that led up to the review, but no such acknowledgement was made. No attempt has been made since to investigate this homicide.
It is five months since Consultant Psychiatrist 7 and I wrote to Director of Adult Specialist Services 1 about the unprogressed SUIs, specifically citing … the homicide.

As per my previous email, I feel it would support me if you could raise these issues and all the other outstanding SUIs with Director of Adult Specialist Services 1. The SUIs are serious matters but are in fact only symptoms of systems malaise that I have tried, but largely not succeeded, in engaging management action on.'

26.30 Consultant Psychiatrist 5 emailed the Chief Executive of CPFT on 9 August 2009. In her email she wrote:

'I write instead to ask for your help with issues relating to serious patient safety matters in prison In Reach services. You very kindly supported the setting up of a review to address the issues raised in February. At that point, one of the issues that had inadvertently become apparent was that Trust mechanisms appeared to have broken down in several centrally registered SUIs.

Since then, outstanding patient safety incidents appear largely not to have been progressed. When I queried this, I was informed that the review would be dealing with these matters. It was then clarified, as I had understood from the outset, that the review was a strategic exercise and would not be dealing with operational work such as reporting and investigating outstanding serious untoward incidents.

On the basis of this, I attempted again to raise the lack of incident progression but have not yet received clarity. In fact, I have not had acknowledgement of my last two communications. This is despite the fact that I have passed on additional information that there now appears to have been an active and irregular decision last September by a senior manager not to progress a homicide. This reported decision was not previously acknowledged in all the months that this homicide has been discussed and written about.

I have also flagged up the fact that I perceive I have been subject to negative treatment due to my raising of concerns. I feel this treatment continues and that this in itself is a clinical governance issue. I have flagged this up as well and I have asked for protection. It is my perception that I have not, thus far, been adequately protected from the negative treatment. I have now been given advice that I may be subject to a vexatious referral to the GMC if I continue causing 'trouble' by pursuing the patient safety concerns. Colleagues have also openly considered career pathways out of the organisation for me.
I have felt marginalised, villified and under enormous pressure. This impacts on my ability to function.
I have followed the Trust's Open Practice policy in raising my concerns through successive organisational layers. I last raised the issues with Medical Director 1 as my Head of Profession. I now raise the issues with you as the next stage.
I would be very grateful to meet urgently and confidentially with you regarding these matters.'

26.31 A discussion appears to have taken place between the Chief Executive and Consultant Psychiatrist 5 on 10 August 2009 in relation to the email of 9 August 2009. Further to that discussion, the Chief Executive emailed Consultant Psychiatrist 5 on 10 August 2009. She noted that an investigation was to be carried out into the concerns raised by Consultant Psychiatrist 5. She also wrote:

'As a result of my conversations there appear to be different views on at least some of the issues you raise. For example you state that you believe that the Trust's mechanisms appear to have broken down in several Serious Untoward Incidents. Director of Adult Specialist Services 1 is of the view that in the cases you have raised with her the Trust's processes have been followed with the SUI being reported and investigated through the prison system.'

26.32 A meeting was organised for 10 September 2009 in relation to the reporting of SUIs and Incidents. Consultant Psychiatrist 5 was not able to attend the meeting. The purpose of the meeting was identified as:

> *'To ensure that there was clarity in requirements and expectations in regard to the reporting and investigation of near misses, incidents and SUIs and;*
>
> *To undertake a status update of the outstanding SUI's / incidents for the prison in-reach team and ensure these were allocated appropriately.'*

26.33 The meeting considered outstanding SUIs that involved prisoners. Three cases were discussed and were deemed not to qualify as SUIs as they either did not meet the criteria of the SUI policy or the prisoner involved was not under the care of the MHIRT. It was agreed that these cases would be recorded as 'incidents'.

26.34 The record of the outstanding SUIs and incidents at the end of the meeting log records the death of the Deceased as '*Prisoner assaulted*' and Team Manager 1 as being the investigating manager. The meeting note states that it was '*Agreed by Director of Adult Specialist Services 1 that as neither persons involved had mental illness, this case should be reported as an incident on datix and Team Manager 1 to undertake a review as to any further actions to be taken*'.

26.35 On 21 November 2009, Consultant Psychiatrist 5 sent an email entitled 'Formal SUI registration' to Director of Adult Specialist Services 1, the Head of Integrated Governance, and Team Manager 1. She stated:

> *'Pending clarification of joint SUI process with partner agencies I am submitting formal SUI reports on outstanding grave patient safety incidents from the prisons. I feel that the cases meet the SHA's SUI criteria in terms of harm and risk to the patients or others, but also because of serious process breakdown associated with the reporting and processing of these incidents, that in itself presents governance and corporate risk.*
>
> *I have sought general advice from the SHA on complex situations where there are several agencies involved. They indicated that they would prefer to receive duplicate SUI reports rather than none. We have so far no assurance data on file to evidence that the prisons have submitted SUI reports on the incidents in question.*
>
> *…*
>
> *The SHA further advised that a deciding factor is that there is something to be learned from reviewing a serious incident, the answer is generally 'yes' as to whether a SUI report should be filed. This seems applicable in the serious outstanding incidents.'*

26.36 Attached to her email of 21 November was a copy of an SUI report filed by Consultant Psychiatrist 5. It describes the incident as:

> *'Alleged to have taken part in the killing of a fellow prisoner, Mr the Deceased, as a joint enterprise with several other prisoners, including Mr B, later also an MHIRT patient. Subsequently there has been process breakdown with organisational risk.'*

Consultant Psychiatrist 5 also stated:

> *'Mr A had a diagnosis of personality disorder but intermittent psychotic symptoms and a family history of psychosis. He a history of violence. There was evidence in the In Reach records that he had been involved in fighting on the wings days before the killing. As regards the serious process breakdown, the matter has not yet been investigated and it has been indicated that there is no assurance data on file to show that liaison with partner agencies took place. It is not clear if the SHA and PCT are aware of this homicide or of CPFT's involvement in the care of this patient. PLEASE CROSS REFERENCE THIS SUI REPORT WITH THAT ON Mr B, THE OTHER IN REACH PATIENT CHARGED WITH THIS MANSLAUGHTER'.*

26.37 On 8 December 2009, an email was sent to various staff involved in Clinical Governance including Consultant Psychiatrist 5, Team Leader 2 and Team Manager 1. This email informed staff of a workshop which had been organised to agree the Clinical Governance yearly plan from March 2010 onwards. This represents an element of best practice.

26.38 On 3 February 2010, Consultant Psychiatrist 5 passed her concerns about CPFT's failure to investigate Mr A's care to the Care Quality Commission. She notified CPFT's Chief Executive of her decision to do this by email. The email states:

> *'I write to you to inform you that as a result of loss of confidence in the Trust's commitment and ability to transparently, appropriately and effectively address the safety issues that I have raised, and my concerns about lack of protection internally, I have now placed the matters in the hands of the Care Quality Commission.*
> *Thank you for the offer of the meeting on 12.01.10 but I am not sure that it is appropriate for this to go ahead given that you have asked for others whom I feel are contributing to the PIDA victimisation to be present. It would not be in keeping with the spirit and general flow of the Trust PIDA policy, which places an emphasis on putting staff who make disclosures at their ease.'*

26.39 On 18 February 2010 Director of Nursing and Quality 1 sent a letter to Consultant Psychiatrist 5 in response to the SUI report filed by her. This letter advised

Consultant Psychiatrist 5 that the Mr A and Mr B SUI had been registered as SUI 146-2008 and was due for completion in March 2010.

26.40 On 11 March 2010, a draft of the SUI 146/2008 Root Cause Analysis Report (the 'Internal Report') was circulated. This covered background information relating to both Mr A and Mr B and a chronology of events as well as the substance of the report. However, it was concluded that as Mr B had been found not guilty, the report would not consider his care any further. This was as a result of a decision taken by Director of Adult Specialist Services 1. The Internal Report includes a section titled 'Care given against the Trust policies and guidance'. This stated:

> *'Risk assessment*
> *There was no evidence of a formal risk assessment being completed. Mr A had self harmed in 2007 but had also used the event to escape from custody. He was offered an appointment with the prison in-reach team by he[sic] did not attend the appointment.*
> *Risk management*
> *The issue of risk management is minimised by the prison environment but in the absence of a formal risk screen the management can not be commented on.*
> *Care planning*
> *The entries on the records were clear and concise and gave a written commentary on the future plan however there was no CPA documentation used*
> *Record Keeping*
> *The records reported the input from Substance Misuse Practitioner 1 the prison in-reach support worker but there was no evidence that this was overseen by the qualified clinicians. The records could have been further enhanced by the searches made and their findings on the previous contacts with services and medication prescribed…'*

26.41 The recommendations of this draft stated that CPA documentation should be used as a matter of routine, as should the CPA risk assessment tools. It noted that staff should adhere to the CPA policy and guidelines and update these on a regular basis. It also noted that staff should be reminded of best practice for record keeping and that unqualified staff input should be countersigned by qualified staff.

26.42 On 15 March 2010, Consultant Psychiatrist 5 made a confidential response to the Internal Report on Mr A. She stated that she agreed with the broad thrust of the report but that there were additional points she wished to make. She pointed out that she had not been formally interviewed as part of the process of producing the report. She also made the following reference to Mr A's medical records which did not form part of the Internal Investigation Team's consideration of Mr A's care:

'Had these Trust notes been obtained, they might have increased the appreciation of the complexity and longstanding nature of Mr A's mental health problems. Obtaining and reviewing such background information is essential in the management of risk in our risky population, but it is timeconsuming. Information is also often scattered in different locations and not necessarily neatly located in one set of notes as above.

…

Further, health staff have a duty to contribute to security process in the prisons, and to file Security Information Reports (SIRs), balancing this where appropriate against the duty for confidentiality. Evidence of violent activity should trigger consideration of whether an SIR should be filed, and if not, ideally a note should be made of the reasons for this. So when Mr A presented with a hand injury from fighting on the wing, a few days before the homicide, this was such an occasion.

Also, Mr A is reported to be of borderline intellect. In the prison context, people of lower IQ can be vulnerable to manipulation by more able prisoners into acting as 'runners' or 'enforcers'. They may also accept such roles to gain acceptance. So although it may seem unlikely at first glance, there may also be paradoxical Vulnerable Adult issues underlying Mr A's predicament in custodial settings. His presentation with a hand injury may have been a sign that he was caught up in a sub-culture that was damaging and risky.'

26.43 At a later stage on 21 March 2010, Consultant Psychiatrist 5 contacted Medical Director 1 to raise a further concern about the Internal Report. Her concern was as follows:

'The Terms of Reference for this investigation do not include an examination of the way in which the incident has been handled. I copy the TOR in appendix (1). I am not sure why this SUI has been given a 2008 identifying serial number when it was never registered in 2008. I did not find it in the Trust SUI database previously. Is it not conventionally the function of serial identifying numbers to ensure that the record should not be amended retrospectively? May I also ask on what date this SUI was registered?'

26.44 On 12 October 2010 a final version of the Internal Report and action plan relating to Mr A's SUI prepared by CPFT was circulated.

26.45 Consultant Psychiatrist 5 submitted the following email to Medical Director 1 of CPFT outlining her concerns about the Mr A SUI process on 23 October 2010. In that email she stated:

'Further to the below correspondence of 15th September 2010, and other more recent correspondence, I write to make you aware as Medical Director and my professional lead of continuing process irregularities and anomalies in information provided about this serious untoward incident. These irregularities

follow the late registration of this SUI this year, at which point it was irregularly allocated a retrospective SUI number of 146-2008, instead of a 2010 serial identifying number,which would have been the convention.'

26.46 Consultant Psychiatrist 5 emailed the Chief Executive on 31 December 2010 setting out a comprehensive summary of her concerns with the investigation process relating to SUIs occurring in CPFT and more specifically her concerns about the SUI conducted in Mr A's care. This included an extensive chronology. Consultant Psychiatrist 5 identified the following as a key concern:

'I am also unsure why it is now implied that Trust homicides cannot be registered as SUIs until after conviction, or that Trust homicide investigations cannot start until after conviction. This is partly because I understand that:
i) Other homicides have been registered as Trust SUIs before conviction, and that
ii) investigations undertaken into other Trust mental health homicides have commenced before convictions in those cases.

Further, neither the DoH guidance from Offender Health nor the NPSA guidance on the investigation of serious incidents, (including specifically the investigation of fatal incidents in prison), indicate that homicide investigations must be deferred until conviction.
…'

26.47 In January 2011, Consultant Psychiatrist 5 raised her concerns relating to patient safety via the Trust's official whistle-blowing procedure.

26.48 On 8 November 2011, the Chief Executive sent an email to all members of CPFT's staff that requested feedback from staff at CPFT of examples where patient care had fallen in the view of the respondents below the level they considered to be acceptable. The email noted that this was in response to an impending visit from the Care Quality Commission.

26.49 On 11 November 2011 Consultant Psychiatrist 5 sent a response via email to the Chief Executive. In it she highlighted ongoing concerns relating to governance:

'In summary, I have been seeking to progress serious governance concerns via a grievance under the Trust's whistle blowing procedure since January of this year. Some of the concerns relate to issues that have been raised but which have remained unresolved over several years. I am waiting for this governance grievance to be heard. My concerns cover a range of issues but broadly revolve around patient safety and the handling of patient safety issues, patients' welfare, rights and Safeguarding.
…

I am not aware that any structured evaluation of the implementation of the recommendations of the 2009 review of the prison In Reach service, as was originally agreed. This was supposed to have taken place between 6-12 months after the publication of the review report. It was due no later than September 2010 but has not taken place. A key recommendation, the establishment of a basic service wide clinical governance structure and process, was not actually set up until July 2010. This was 10 months after the review had concluded. I have received no responses to my last queries about structured evaluation of the implementation of the service review. Implementation is not complete and systems risks remain. This is of concern because as you may recall, the review was originally triggered by concerns about service safety, serious governance breaches and grave patient safety incidents such as the 2008 prison homicide.'

26.50 The Internal Report produced by CPFT was prepared some time after the Deceased's death. It is not best practice that a significant period of time is allowed to elapse following an SUI before a report is prepared. However, in this instance, the delay could have provided those tasked with preparing the Internal Report an opportunity to re-evaluate Mr A's care in light of the changes which had been made to the MHIRT. This did not happen and an opportunity was lost. The view which appears to have been adopted was that significant changes had been made to the service as a whole since Mr A's care. Those changes were not assessed against the facts of Mr A's care to assess whether changes had been made in relation to the issues raised by his case. An opportunity was also missed to build upon the Initial Report produced by the Management Team immediately following the death of the Deceased. The Initial Review included a number of issues which warranted further investigation.

26.51 Neither Mr A, his family, nor the Deceased's family were involved in the Internal Investigation. Mr A's experience of trying to access care unsuccessfully might have provided the Internal Investigation Team with a reliable insight into the operation of the service from the perspective of the patient.

26.52 The Internal Investigation Team also failed to speak to everyone connected with the service who might have had a valuable insight as to how the service operated. This may have deprived the Internal Investigation Team of valuable clues which could have resulted in further learning.

26.53 The recommendations in the Internal Report were not the subject of an audit requirement. Without a requirement to audit, it is not possible to conclusively say that the learning points arising from an investigation have been made.

26.54 Reporting using the DATIX system

26.55 In 2008, CPFT used the DATIX web-based system for incident reporting. This system allows prompt, thorough reporting lines and recording of actions taken, so that learning from the incident can be disseminated.

26.56 DATIX is a web-based incident reporting system that can be used by anyone with access to the NHS net. When a member of staff witnesses an incident or near miss, they can access the website and complete a form on-line, which is then sent off to their line manager for review and completion of additional action taken.

26.57 The DATIX form asks for details of the incident and the organisations and people involved. It collects information about immediate and further action taken so that any learning is shared. Some information is collected because it is required by the NPSA as part of their collation of all patient safety incidents.

26.58 The form acts as both a record of the incident and a prompt to support action planning and reporting. Thus the member of staff completing the form should include as much information as possible, so the reasons for the incident can be reviewed and appropriate action taken to avoid reoccurrence.

26.59 A high level of reporting within an organisation indicates a better safety culture: the more aware staff are of safety problems, the more likely they are to report. High levels of patient safety incident reporting suggest a stronger organisational culture.

26.60 It is a matter of concern for the Independent Investigation Team that the death of the Deceased was only recorded on DATIX following a meeting between a number of individuals responsible for the management of the MHIRT, including Director of Adult Specialist Services 1, on 10 September 2009. This suggests a poor understanding of the benefits to learning which can be achieved from sharing the knowledge of untoward incidents.

26.61 Mental health organisations manage multiple systemic risks which have variable visibility to frontline staff. A mature, high-functioning safety culture will ensure that clinical and managerial staff are aware not only of the individual service user risks, but also of the risks associated within the systems that they are working. This culture is an essential framework for staff to be able to identify, own and manage risk within the organisation.

26.62 Building a safer culture depends on strong leadership with clear policies in relation to safety, and a willingness to implement best practice at service level. A key constituent of this is the strength of an organisation's reporting mechanisms and procedures.

26.63 CPFT's Reporting Mechanisms

26.64 As an organisation, CPFT has experienced some difficulties in the strength of its reporting mechanisms. CPFT became increasingly aware of incident management issues during 2008 and 2009 which had led them to commission a number of reviews.

26.65 For example, a report entitled 'Audit Report: Serious Untoward Incidents: Quality of Reporting' (the 'Audit Report' was produced by Dr Kumar and Dr Dodwell in early 2008. The main findings of the Audit Report were as follows:

- A total of 50 SUI's were reported in 2007. Of these 35 involved a death.
- An initial report was prepared within 24 hours in relation to 29 cases. In 8 cases, the initial report had been finalised at the time of the audit. Only 13% of cases had a final report within 45 days. Out of the 16 final reports available 13 had Action plans documented.
- Elements of good practice identified were as follows:
  - Local trust policy developed;
  - More incidents are being reported;
  - All the initial reports were available electronically;
  - Reminders sent 7 day update and final reports;
  - Majority of initial reports are complete; and
  - Majority of the final reports had an action plan.
- However, the Audit Report highlighted the following areas of concern:
  - Delay in logging initial reports;
  - Half of the final reports had poor quality action plans;
  - Initial reports lacked detailed account of the actual incident; and

- o More than half of the reviews/final reports are pending or not available on the database.

26.66 An external organisation, Mental Health Strategies, was commissioned by CPFT in May 2009 to look at a number of serious incidents that had occurred in acute care services from January 2009. The report that resulted from the Mental Health Strategies Review made a wide range of recommendations about required improvements to incident management as well as practice issues highlighted through the Mental Health Strategies Review. Recommendations included:

- Improved leadership, governance and audit, policy updates including clearer incident grading and reporting tools, improved training and dissemination of lessons learnt, increased staff awareness of policies for admission, Care Programme Approach (CPA), improved communication within the Trust and externally with other agencies and GP's.

26.67 An action plan was put in place with implementation being monitored by a Steering Group, as well as the Governance Committee and the board of CPFT.

26.68 Following the Mental Health Strategies Review a retrospective review was undertaken at the end of 2009 of all serious incidents occurring from January 2006 to December 2009. The retrospective review, which examined 147 cases, looked at whether incidents had been categorised correctly, whether they had been investigated, and at the quality of the investigation process and action plan outcomes. The findings of the retrospective review were presented to the board of the CPFT and included the need for a clearer definition of the categories of incidents, a consistent reporting format and improved governance arrangements. Actions identified in respect of incident management processes were then encompassed in the Mental Health Strategies Review action plan. In addition a further action plan was developed to include all areas of practice/actions that were highlighted for improvement through the investigation processes.

26.69 The Review conducted in 2009 of the MHIRT also looked at incident reporting issues and the barriers to effective incident management across the prisons. It was recognised that not all incidents had been reported and where they had been reported learning had not always been actioned. A steering group was set up and an action plan was adopted to address concerns.

26.70 Following the Mental Health Strategies Review, CPFT updated its policies and procedures to include more robust processes for incident investigation. A new policy entitled 'Near Miss, Incident and Serious Incident (SI) Policy and Procedure' was implemented in February 2011. In addition, CPFT have also appointed additional senior members of staff as SI investigators. These individuals will form part of the newly formed Nursing and Clinical Directorate.

26.71 The CQC also became concerned about the quality of CPFT's handling of serious incidents. On 11 May 2010, the CQC visited the Trust in order to assess the progress which the Trust had made in addressing its previous difficulties in these areas.

26.72 Prior to the inspection, the CQC identified a range of incidents which had occurred prior to December 2009 that had not been fully investigated. CPFT was aware of the majority of the incidents. Investigation reports were acknowledged by CPFT to be of variable quality in terms of content, processes undertaken, and learning outcomes. It was also acknowledged that some of the incidents were not reported at the time they had occurred and were only later highlighted through retrospective review.

26.73 Following the inspection the CQC also met with both of the PCTs that commission CPFT services to gauge their opinions as to CPFT's performance in respect of serious incident management. Both PCTs stated that the Trust had not effectively managed incident investigation and reporting processes in previous years. However, both acknowledged a marked improvement during 2010 in respect of clearing through a backlog of investigations, robustness of investigations and the timeliness in reporting incidents to the PCTs.

26.74 The CQC were able to conclude that the evidence demonstrated that CPFT had made some improvement in ensuring that people who use its services benefit from improvement made by learning from adverse events, incidents, errors and near misses that happen, but that further work was required.

26.75 The Independent Investigation Team have gained the impression that there was a significant degree of reluctance in commencing an SUI into Mr A's care. The Independent Investigation Team are of the view that such a degree of reluctance could indicate a potential cultural issue which could be detrimental in extracting the learning from events such as that involving Mr A and tragically the Deceased. The Independent Investigation Team notes that considerable changes have been made to CPFT's SUI procedures and systems since 2008. In order to maximise the potential for learning to be extracted from events, which can prove traumatic for staff and

patients alike, it will be necessary for the Board of CPFT to monitor the effectiveness of it new policies to ensure that these changes are underpinned by cultural changes in the behaviours throughout CPFT.

26.76 Key Points

1. Information was handed to the CPFT management team regarding the Deceased's death on 17 September 2008. Two MHIRT patients were involved in the attack on the Deceased.
2. The issues arising from Mr A's care at that time were said to be:

a) lack of risk assessments;
b) loose practices in closing files;
c) lack of clarity concerning Mr B, as to whether he was receiving care from the MHIRT;
d) role of Substance Misuse Practitioner 1 was unclear; and
e) poor records.

3. An initial report (the 'Initial Report') was compiled on 24 September 2008. The Initial Report was compiled using Mr A's records and those of Mr B.
4. The Initial Report was not compiled in accordance with Trust Policy or in accordance with NPSA Guidance. However, it did contain some elements of good practice. In particular, the Initial Report recognised that a more in depth investigation was necessary in order to establish whether the contact which the MHIRT had with Mr A or Mr B was relevant to the death of the Deceased. Further, it identified that pathways were unclear and that there were difficulties in identifying whether a service user was in receipt of care from the MHIRT.
5. Two consultant psychiatrists wrote to the Director of Adult Services at CPFT on 6 February 2009 raising concerns about the care of Mr A and Mr B. They asked why the death of the Deceased had not been reported as an SUI which would have allowed the matter to be reviewed internally. A number of other concerns were raised by the consultant psychiatrists relating to poor clinical governance practices within the MHIRT.
6. A meeting took place with members of senior management team on 7 April 2009. Following this meeting the Review of the MHIRT was commissioned.
7. The Deceased's death was not recorded on the DATIX system until after a meeting was held on 10 September 2009.
8. Despite persistent attempts by Consultant Psychiatrist 5, a Consultant Psychiatrist, to ensure that the Deceased's death was registered as an SUI with CPFT and for that

SUI to be registered and investigated internally, it was not until 11 March 2010 that a draft SUI report was prepared for circulation.

9. There appears to have been confusion within the Board of CPFT as to the criteria and processes necessary to undertake an SUI. It appears that it was felt necessary that a conviction should occur prior to any internal investigation being commenced. This caused unnecessary delay.
10. CPFT has experienced a significant level of criticism in relation to how it investigates SUIs. The CQC has been critical of it. CPFT's response initially was to commission a number of reviews which confirmed the problem. A new policy concerning SUIs has been introduced entitled 'Near Miss, Incident and Serious Incident (SI) Policy and Procedure' in February 2011.
11. In relation to the death of the Deceased, the management team of the MHIRT initially acted slowly but appropriately in reporting the Deceased's death to the Board of CPFT. Difficulties apparently arose at Board level which appear to have prevented the Deceased's death being investigated promptly and effectively. This is a concern because it is the Board which establishes the culture of an organisation and the failure to initiate an investigation of this nature suggests an inadequate cultural approach towards safety. The Independent Investigation Team accepts that there have been significant changes to the membership of the Board of CPFT following the Deceased's death which will impact upon the culture of the organisation.
12. The Independent Investigation Team are also very concerned that Consultant Psychiatrist 5, a consultant psychiatrist, was forced to take steps to have the death of the Deceased investigated and indeed in doing so involved the whistle blowing procedure available to all employees. The Independent Investigation Team are concerned by the references made in correspondence by Consultant Psychiatrist 5 suggesting that she felt *'marginalised'* and *'vilified'*. In a culture which embraces openness, in an attempt to secure patient safety, NHS staff should be supported in raising concerns to allow a culture of learning to develop with the attendant benefits for patients.
13. The Internal Investigation which was eventually performed by CPFT in relation to Mr A's care was at best cursory. Whilst it is acknowledged that a significant number of changes had taken place in the governance regime of the MHIRT, the Internal Investigation did not seek to fully establish what had been the issues involved in Mr A's care. Indeed, the Internal Investigation did not pick up issues highlighted in the Initial Report, such as the difficulty in establishing a proper case load, in order to

check that this learning point had been accepted and dealt with. This is a cause for concern.

27.0 PREDICTABLE OR PREVENTABLE?

27.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the Deceased's death was preventable or predictable.

27.2 Many Independent Investigations, like that conducted in this instance, identify missed opportunities about the perpetrator's care or a failure to appreciate the extent of the perpetrator's difficulties or to provide good quality care. In these cases, there may be evidence of failure in carrying out individual policy requirements or that the care delivered may not have exhibited features of best practice. However, this does not mean that the homicide could have been either predicted or prevented.

27.3 The Independent Investigation Team has applied the following tests to assess whether the Deceased's death could have been predicted or prevented:

The homicide is predictable if there was evidence from Mr A's words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had not been noticed or had been misunderstood at the time it occurred.

The homicide could have been prevented if there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done better.

27.4 In considering the issue of predictability, the Independent Investigation Team has given consideration to the factual scenario which resulted in the Deceased's death, as this is relevant to the issues of predictability and preventability.

27.5 His Honour Judge Jacobs, in sentencing Mr A in relation to the death of the Deceased, made the following comments:

> *'you were indicted on the basis there had been effectively a plan to assault and rob the Deceased of his heroin…I have come to the conclusion that the evidence now shows no more than an intention to confront that rapidly spilled over into violence and theft.'*

He went on to say:

'…to an extent this was spontaneous violence; that, the obvious point, it is manslaughter and not murder, one of the reasons being there was no intent to do serious harm, but I have no doubt that by the end of this, there was an intent to intimidate and to steal'.

The Judge made it clear that in his view,

'…this is not a case of murder. Death was not intended, but the violence was unlawful.'

27.6 In addition, the Independent Investigation Team believes that it is important to remember that the Deceased died as a result of cardiac problems brought on by the stress of the attack upon him. The physical injuries which he sustained would not of themselves have been sufficient to cause his death.

27.7 Predictable

27.8 Mr A was not the subject of formal risk assessment at any stage by the MHIRT.

27.9 Mr A had displayed a history of violence which is more fully set out in the various psychiatric reports referred to in Section 17. A significant risk factor for physical violence is a past history of physically aggressive behaviour.

27.10 Mr A was not the subject of a risk assessment by the MHIRT. A risk assessment would have identified several historical risk factors and, more importantly, clinical or dynamic risk factors. Such an assessment would also have provided a risk formulation to guide future care and specifically to manage, or attempt to manage, the identified risk. Such a risk formulation may have hypothesised that the risk of Mr A offending increased when under the influence of alcohol and drugs. It could also have explored the importance of the paranoid feelings which Mr A had and whether these were linked to homicidal or aggressive thoughts. Also relevant to any risk assessment would be whether the reports made by Mr A of 'paranoia' were a new symptom, in which case it may have constituted a dynamic risk factor.

27.11 The Independent Investigation Team has not been provided with any risk assessments undertaken by the Probation or Prison services prior to Mr A seeking assistance from the MHIRT. An actuarial risk assessment such as the OGRS-2 would have provided a probability of future violence but on its own it would have been of limited value. This is because, being based on population statistics, it would not have been specific to Mr A. It would only have allowed the conclusion to be drawn that out of a group of people like Mr A, x% would engage in further violence and y% would

not, but it would not assist as to whether Mr A was going to be one of the x% or one of the y%. In addition it does not allow risk to be considered in terms of static and dynamic risk factors.

27.12 A structured clinical risk judgment tool such as the HCR-20 would have identified static (historical) risk factors and also highlighted particular dynamic clinical risk factors and risk management factors specific to Mr A that could increase Mr A's level of individual risk. In this was Mr A's risk could have been monitored in a dynamic way and subsequently informed risk management plans accordingly. Examples of such dynamic risk factors would include active symptoms of major mental illness or exposure to destabilisers and stress. Other HCR-20 risk factors include substance misuse problems, personality disorder, and impulsivity.

27.13 Risk assessment is not an end in itself but is a mechanism for developing and informing strategies for identifying and managing risk. The most important purpose of the risk assessment is the development and implementation of a risk management plan. Risk assessment tools contribute to risk management by identifying risk factors which can be reduced through the provision of an appropriate program of intervention and by identifying the appropriate level of monitoring or supervision of the offender.

27.14 The Independent Investigation Team's view is that it was predictable that Mr A could behave violently and he had done so historically. During the course of Mr A's trial, the Judge accepted that those involved in the attack upon the Deceased were responsible for spontaneous violence without an intention to do serious harm.

27.15 The level and pattern of violence which Mr A exhibited during the attack on the Deceased were consistent with reports of his previous violent behaviour which are noted in his MHIRT records and are discussed at Paragraphs 16.3 and 16.5. The level of violence which Mr A could be predicted to display impacts upon the issue of whether it was predictable that death could occur as a result of that violence. The Independent Investigation Team does not believe that it was predictable that Mr A would act violently at such a level that the degree of injury caused would lead to death, without other independent factors such as the cardiac problems experienced by the Deceased being present. The Independent Investigation Team therefore concludes that the homicide of the Deceased was not predictable.

27.16 Preventable

27.17 None of the failures identified in this report should have happened. The cumulative effect of these failings meant that Mr A was effectively unassessed and potentially untreated either for an emerging mental disorder or a longstanding personality disorder, or both. In addition, Mr A had not undergone a formal risk assessment process. However, there is no basis upon which the Independent Investigation Team could conclude that, even if Mr A had been fully and appropriately assessed, such an assessment would have resulted in psychiatric or psychological intervention, such as medication or psychological therapy, which would have had an impact on his paranoid thoughts or violent behaviour. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always areas of care provision that could be carried out more effectively.

27.18 Even if Mr A had been fully assessed and psychiatric or psychological interventions implemented, it does not follow that the risk of violent behaviour would have been reduced. Not only is there uncertainty about the likely effectiveness of such interventions in his case but, particularly in a custodial environment, the outcome for any one individual can be influenced by a range of factors that are outside the control of professionals such as those in the MHIRT.

27.19 For example, research has found that Dialectical Behaviour Therapy ('DBT') in partial hospital programmes is an effective treatment for BPD patients who also suffer from impulse control problems such as substance abuse (Lieb, 2004). In a study led by Marsha Linehan, DBT was tested in a randomised clinical trial to evaluate its effectiveness as a cognitive-behavioural strategy for drug-dependent BPD patients. Patients were randomly selected into DBT or Treatment as Usual ('TAU') conditions for one year of treatment, and were assessed at 4, 8 and 12 months, and at a 16 month follow up. In this study, patients who underwent the DBT condition had significantly lower rates of drug abuse compared to the TAU group, as measured by structured clinical interviews, and urine analyses throughout the study. Patients also showed greater global and social functioning at follow up (Linehan et al, 1999). Similarly, a study by Batemen and Fonagy (2008) evaluated the effect of mentalisation-based treatment ('MBT') by partial hospitalisation, compared to treatment as usual for borderline personality disorder. This study looked at patients eight years after entry into a randomised controlled trial, and five years after all mentalisation-based treatment was complete. The results suggested that the group given mentalisation-based treatment by partial hospitalisation continued to show

clinical and statistical superiority to the control group, who received the standard treatments then provided to patients with borderline personality disorder, on suicidality, diagnostic status, service use, use of medication, global function and vocational status. However, formal MBT and DBT programmes (which included group and individual psychotherapy for at least 12 months) are extremely rare within a prison setting, and when such approaches are available they are usually a watered down version of the approach provided on a one to one basis.

27.20 For example, in order to achieve significant therapeutic results through psychological interventions for personality disorders, the patient has to engage fully with the professionals providing care in order to achieve maximum benefit. Treatments are often lengthy, which increases the risk of non-engagement. It should be noted that Mr A in the past failed to engage with services in relation to his substance misuse issues (see Paragraph 17.24). Secondly, many psychological therapies, including DBT, are unavailable in the prison environment. In a limited number of prisons, there are treatment programs specifically designed for individuals with personality disorders known as ‘therapeutic communities’. However, the exclusion criteria often include substance misuse and self-harming, thereby excluding a large number of borderline personality disorder patients within the prison setting from accessing this limited resource.

27.21 As a result, notwithstanding the deficiencies in the delivery of care to Mr A by the MHIRT and a failure to formally assess the risk which he posed as a result, the Independent Investigation Team does not believe that the Deceased’s death could have been prevented by members of the MHIRT in relation to their care of Mr A.

27.22 Key Points

1. The Independent Investigation Team is of the view that it was predictable that Mr A could behave violently.
2. The Independent Investigation Team does not believe that it was predictable that Mr A would behave so violently that he would kill someone unless there was an independent contributory factor such as, which was the case here, pre-existing heart disease.
3. The Independent Investigation Team does not believe that the Deceased’s death was preventable by members of the MHIRT.

28.0 SUMMARY OF RECOMMENDATIONS TO IMPROVE PATIENT SAFETY

28.1 During the course of its investigations, the Independent Investigation Team have highlighted a number of areas where service delivery could be improved for the patients of the MHIRT. These are set out in the 'Additional Learning' sections of this report.

28.2 The following table sets out a number of recommendations which the Independent Investigation Team believe are appropriate in order to maximise the learning which it believes arises from its examination of the care provided to Mr A.

Recommendation 1	CPFT to prepare a detailed action plan, incorporating a timetable and measurable deliverables, in relation to the Bradley Report to ensure that the recommendations of the Bradley Report have been incorporated into MHIRT practices and procedures with a view to improving the provision of services to offenders with dual mental health and substance misuse issues.
Recommendation 2	CPFT conduct a review of the policies operated by the MHIRT in order to ensure that all aspects of its operations are fully documented and include appropriate 'failsafe' measures including the systems and procedures concerning the Alert Clinics.
Recommendation 3	CPFT should undertake a review of the clinical governance policies and procedures operated by the MHIRT in order to ensure that all CPFT policies have been appropriately tailored to take account of the specific challenges posed by a custodial environment.
Recommendation 4	CPFT and the MHIRT should undertake a review of the pathways through which information concerning offenders is received, requested and recorded in order to ensure that information concerning the needs of individual offenders and the risk that they pose is available to all members of the MHIRT.
Recommendation 5	Prompt consideration should be given to a formal protocol being adopted, governing the roles and responsibilities of the IDTS and MHIRT and the individuals involved. This protocol should take into account the clinical governance and care co-ordination responsibilities of MHIRT and IDTS.
Recommendation 6	A dedicated meeting should be established for senior managers from the Prison service and CPFT to review on an on-going basis, policy documentation in areas of joint practice, on a regular basis. In addition, there would be considerable merit in those individuals identifying and reducing their respective operational components to a single standalone practical guide that is accessible and available to all staff.

Recommendation 7	The MHIRT should formulate its risk management and CPA processes into one source document in line with the innovative practice models currently being adopted in the CPFT. This would allow greater transparency and scrutiny by the Board of CPFT.
Recommendation 8	CPFT should increase the level of access to a Consultant Psychiatrist available to the MHIRT in order to comply with National Guidelines at all times.
Recommendation 9	CPFT should review its policies and procedures relating to its treatment of staff who raise concerns about issues of poor practice with CPFT in order to encourage openness and engender a culture of patient safety.
Recommendation 10	A review should be conducted to ensure that the MHIRT is fully compliant with the incident reporting and investigation regime now operated by CPFT, including an assessment of the quality of the decision making processes leading to referral for internal investigation of adverse events.
Recommendation 11	A review should be conducted by CPFT to ensure the quality of the decision making processes in relation to the Alert Clinics.