An independent investigation into the care and treatment of a person using the services of Nottinghamshire Healthcare NHS Trust

Undertaken by Consequence UK Ltd

Ref Mr S

October 2012

This is the report of an independent investigation commissioned by the previous NHS East Midlands SHA (now NHS Midlands and East) to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent investigation of adverse events in mental health services"*, issued in June 2005. The guidance replaces paragraphs 33-36 in HSG (94)27 (LASSL (94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services[1] in the six months prior to the event.

The Independent Investigation Team members were:

- Maria Dineen, Director, Consequence UK Ltd;
- Justin O'Brien, Head of Patient Safety, South West London and St George's Mental Health Trust;
- Dr Anil Banymandhub, Consultant Psychiatrist, South West Yorkshire Partnership NHS Trust.

Acknowledgements

The Independent Investigation Team wishes to thank:

- Mr S, the service user;
- Mr S's sister;
- Nottinghamshire Police;
- Mr S's consultant forensic psychiatrist;
- Mr S's housing provider in Nottingham;
- Staff working for Nottinghamshire Healthcare NHS Trust;

for their co-operation during this investigation.

Throughout this report, the Independent Investigation Team is referred to as the Independent Team.

[1] Specialist mental health services are those mental health services that are provided by mental health trusts rather than GP and other primary care services. Usually, persons in receipt of specialist mental health services will have complex mental health needs.

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EXECUTIVE SUMMARY

Incident overview and intention

In 2010 Mr S confessed to the unlawful killing of a male known to him. Because Mr S was a service user of Nottinghamshire Healthcare NHS Trust at the time the incident occurred, there was a requirement for the care and treatment Mr S received from that service to be scrutinised under the auspices of health circular guidance HSG 94(27).

Terms of Reference

The terms of reference for this HSG (94)27 investigation were as follows:

To undertake a validation review of the internal investigation report provided by Nottinghamshire Healthcare NHS Trust into the care and treatment provided by them to Mr S and to determine whether or not it met the standard of reasonableness, and what (if any) additional investigation work was required to deliver the principle underlying HSG (94)27.

The Independent Team was asked to:

- Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.
- Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.
- Assess whether the analysis undertaken is reasonable and proportionate and accurately reflects the issues identified with the quality of health and social care provided to Mr S.
- Review the Trust's policies and procedures to validate their compliance and that this was accurately reflected in the internal investigation report, paying particular attention to:
    - The Care Programme Approach;
    - The risk assessment process;
    - Care plans; and
    - The Mental Health Act assessment.
- Establish whether the recommendations identified in the Trust's internal investigation report are appropriate and would mitigate against the issues identified.
- Identify any additional learning from this investigation through applying root-cause analysis tools and techniques as applicable.
- Report the findings of this investigation to East Midlands Strategic Health Authority, now NHS Midlands and East.

Conclusion
As a consequence of its

- analysis of Mr S's care and treatment;
- analysis of Nottinghamshire Healthcare's internal investigation report and interview records;
- meeting with Nottingham City Homes;
- meeting with Nottinghamshire Police;
- meeting with Nottinghamshire staff; and
- meeting with the sister of Mr S;

the Independent Team confirms its conclusion, as stated at the beginning of section 5 of this report, that the overall care and treatment of Mr S was of a good standard and that consultant [1] and the reallocation CPN are to be particularly commended on the efforts they made to make the transition of Mr S from a county-based community mental health team to a city-based one as smooth as possible for him.

Predictability
With regards to the predictability of the incidents that occurred, the Independent Team does not believe that the mental health services could have reasonably predicted that Mr S would act as he did. Mr S had attended reliably for his medication by injection between July 2006 and the end of December 2009. Although Mr S had been erratic in his attendance at outpatient appointments, bar 2007, he was seen at least annually and on these occasions he was also accompanied by his sister. Although asked about his voices and hallucinations, Mr S did not divulge to any professional that he continued to believe that he was bugged, or that he had a special mission to carry out. Mr S's sister did not raise any concerns with the mental health services about her brother over this same period. In fact, Mr S's sister had no information to provide, as she was not at all aware that her brother continued to harbour these unusual beliefs.

Preventability
The only information that might have alerted mental health services to a possible deterioration in Mr S's mental state was held by Mr S's housing provider. The Independent Team considers that reasonable effort was made by the housing provider to determine whether or not Mr S was in receipt of mental health services in March 2009. The housing provider reported to the Independent Team being informed by the mental health service that Mr S was not in receipt of mental health services. The lapse of information transfer to the housing provider meant that Mr S's community mental health team was not aware at any stage of the concerns that prompted Mr S being discussed at a vulnerable person's panel in April 2009. Had the communication mental health team been aware, and in particular had they become aware about the graffiti considered attributable to Mr S, then they told the Independent Team that they are confident that they would have made assertive efforts to have assessed Mr S at home, and under the Mental Health Act if necessary.

However, even had this occurred with the resulting enhancement of Mr S's CPA status, all of the information provided to the Independent Team, including that provided by Mr S's sister, suggests that it would not have been possible to have prevented the incident that occurred between the two brothers. Mr S's sister had been seeing Mr S daily in the antecedent period to the incident and she had detected nothing that she believes could have predicted the events that were to unfold.

Underlining this is the fact that, when Mr S was assessed in custody and under the Mental Health Act by a consultant in forensic psychiatry, Mr S was determined to be fit for interview. The clinical records of this assessment report *"no evidence of psychosis during the interview"* and that there was nothing that led the assessing consultant to *"believe he* [*Mr S*] *was unwell".*

In addition to the immediate post-arrest assessment, the pre-sentencing psychiatric report in August 2010 concluded that in all probability Mr S had consciously withheld information about his symptoms from the clinicians who had come into contact with him. In such a circumstance, and with no conflicting information coming from Mr S's sister, it is unlikely that the mental health professionals would have been able to have prevented the incident that occurred.

The Independent Team's analysis of the care and treatment of Mr S and the subsequent evaluation of Nottinghamshire Healthcare NHS Trust's internal investigation report has resulted in seven recommendations. Five are for Nottinghamshire Healthcare NHS Trust and two for Nottingham City Homes. The recommendations are:

Recommendation 1: Nottinghamshire Healthcare NHS Trust needs to ensure in its redesign of its electronic record that the facility to register a different correspondence address to the service user's own address is included.

In this case and currently there is complete reliance on individual staff to remember where an alternative correspondence address is required and this is neither satisfactory nor necessary.

The Independent Team suggests that the electronic record asks for confirmation of the correspondence address before allowing a professional to progress with the completion of the demographic information about a service user.

In addition to the above, the Independent Team suggests that Nottinghamshire Healthcare NHS Trust explores the feasibility of including a 'cc' prompt on all correspondence templates contained as integral components of the electronic system. The 'cc' prompt list could include the following:

- the service user;
- care co-ordinator;
- GP;
- family member/carer; and

- ‘alternative correspondence address’.

Target Audience
Chair of the Clinical Records Group; the Chair of the Electronics Records Group/ Associate Medical Director Local Services the Clinical Information Systems Manager and the Project Manager for the Implementation of the electronic patient records project.

Timescales
The Independent Team does not consider it appropriate to determine timescales for the above recommendation. Nottinghamshire Healthcare NHS Trust has an electronic records development project currently underway and the above recommendation needs to be placed as a component of the development work already committed to. The Trust must advise the SHA and its commissioners regarding its plan in relation to this recommendation within three months of the acceptance of this report.

Recommendation 2: Nottinghamshire Healthcare NHS Trust needs to include in its routine demographic information collected on each service user details related to literacy. In this case, the first time the professionals appreciated that Mr S had literacy problems was during the independent investigation process. This situation is completely avoidable.

The Trust electronic records working group needs to be instructed to incorporate two ‘forced field’ questions about literacy in its demographic data. One question should be related to reading ability and one question relating to the service user’s ability to write.

The Independent Team suggests that the expert advice of its speech and language therapists could be utilised in determining precisely what information is necessary so that the data is clinically useful to frontline staff.

Target Audience
Chair of the Clinical Records Group; the Chair of the Electronics Records Group/ Associate Medical Director Local Services the Clinical Information Systems Manager and the Project Manager for the Implementation of the electronic patient records project.

Timescales
The Independent Team does not consider it appropriate to determine timescales for the above recommendation. Nottinghamshire Healthcare NHS Trust has an electronic records development project currently underway and the above recommendation needs to be placed as a component of the development work already committed to. The Trust must advise the SHA and its commissioners regarding its plan in relation to this recommendation within three months of the acceptance of this report.

Recommendation 3: Nottinghamshire Healthcare NHS Trust needs to engage with the lead for the Public Protection Unit at Nottinghamshire Police to explore how the Police National Computer facility can be appropriately utilised by mental health professionals where it is considered that it is in a service user's interest, or in the interests of public safety, for a mental health alert to be notated on the PNC for a named individual. Such an alert means that, if the named individual is stopped by the police under circumstances reflecting the mental health alert, then there is a greater likelihood that mental health services would be informed and would be in a position to determine the need for a mental health assessment.

In this case, there was no mental health marker on Mr S's mental health record. Although it cannot be said that, had there been such a marker, the incident that occurred could have been avoided, what can be said is that, had a marker been added to Mr S's PNC record, then there would have been a trigger for the police to have notified mental health services of concerns regarding Mr S in March and November 2009. This would have impacted on his mental health treatment package and resulted in enhanced monitoring of him.

Target Audience
Service Managers for City and County Adult Mental Health Services, Head of Integrated Governance and Performance, Clinical Leads for Adult Services and relevant senior managers in Older Persons' Services and Child and Adolescent Services.

Timescales
The Independent Team recommends that Nottinghamshire Healthcare NHS Trust provides the SHA and its commissioners with its projected timetable and action plan in relation to the above within three months of its acceptance of this report.

Recommendation 4
The assessment of the Trust's internal investigation has identified the need for Nottinghamshire Healthcare NHS Trust to further develop the standard of its serious untoward incident investigations and in particular the presentation of the investigation reports written, so that the investigation report:

- Clearly sets out the terms of reference to which the investigation was delivered.
- Makes transparent the investigation methodology and the investigative tools and techniques used.
- Makes clear the aspects of the service user's care and treatment that meet or exceed local/national policy expectations.
- Makes clear the areas where significant lapses in care and treatment standards have occurred.
- Sets out the contributory factors to each identified significant care and/or treatment lapse and makes clear those contributory factors that are

considered by the investigation team to have had the greatest impact. (These could be termed ‘root causes’.)

- Delivers recommendations that address identified ‘root causes’ and are formulated so that they meet S.M.A.R.T. criteria.
- Makes clear the overall conclusions of the investigation team in relation to the terms of reference set and also in relation to the realistic potential for incident predictability and preventability.
- Where specific questions are agreed as requiring an answer in the investigation report, and these are set out alongside the terms of reference, the committee quality assuring the internal report must satisfy itself that these questions have been responded to and that the information presented is backed up by the information gathered during the investigation process.

The Independent Team suggests that the following will assist the Trust in consistently achieving the above:

- Appointing as the investigative lead a suitably senior individual (minimum band 8) who has received specific training in how to conduct an investigation and how to incorporate systems analysis (RCA) where required.
- Providing mentorship to those staff tasked with leading serious untoward incident investigations, notably homicides, absconding from a secure environment, in-patient suicides, and serious cases of assault to staff/visitors/other service users.
- Consideration of implementing a buddying system for a period of time while the Trust builds up its in-house investigation expertise.
- Using consultant-grade staff as clinical advisors to serious untoward incident investigations, rather than the lead professional in the investigation process.
- Having a clearly developed investigation report template with an accompanying style sheet and guidance notes, so that the author of the investigation report is guided through the process. The National Patient Safety Agency devised a number of resources to assist Trusts in evolving a report template that meets the national standard requirements, as well as the needs of local organisations.

Timescales

The Independent Team is aware that Nottinghamshire Healthcare NHS Trust has invested in the provision of investigation training for some of its staff. However, the reports seen by this Independent Team do not show the effectiveness of this. The Independent Team suggests that the Trust should present its proposal for achieving this recommendation to its commissioners within three months of the publication of this report.

Recommendation 5: There were omissions in the Mr S report that should have been identified and addressed via an effective quality assurance process.

The Trust must therefore devise a common set of criteria against which each Level 2 serious untoward incident investigation report is benchmarked. This set of criteria must be implemented across the relevant divisional committees who oversee and have responsibility for the acceptance of and quality assurance of serious untoward incident reports on behalf of Nottinghamshire Healthcare NHS Trust.

The Independent Team suggests that the following could be components of such a tool:

- Does the report have an Executive Summary that sets out:
  - The reason for the investigation;
  - The purpose of the report;
  - The main findings of the investigation team;
  - The conclusion of the investigation team;
  - The recommendations of the investigation team?
- Are the terms of reference plainly stated?
- Is the investigation methodology clearly described, including a list of the investigation tools and techniques utilised (this could be in an appendix)?
- Does the findings section of the report set out:
  - What aspects of care and treatment met with the required/expected standards?
  - The aspects of the care and treatment that significantly fell below the expected standards (if any)?
  - A systems analysis (i.e. root-cause analysis) for each individual aspect of care and treatment that fell significantly below the required standard. And are the most significant influencing factors stated plainly (i.e. root causes)?
  - Does the report comment on:
    - compliance with the care programme approach;
    - the quality and completeness of risk assessments, risk management plans and crisis intervention plans;
    - family/carer involvement by the responsible clinical team;
    - communication with partner agencies also engaged with the service user;
    - safeguarding issues where relevant?
  - If recommendations are made, do they target the 'most significant influencing factors' of the identified lapses in care and treatment?
  - Are the recommendations S.M.A.R.T.?
  - Are the conclusions of the investigation team clearly stated?

In assessing the above points the relevant committee must assure itself that the findings stated in the report are evidence based and that the language of the report is appropriate and objective.

Target Audience

The Medical Director and Head of Integrated Governance and Performance.

Timescales

Although seemingly straightforward, it may take the Trust's serious untoward incident committee some time to agree its final assessment tool for the benchmark of future investigation reports. Consequently, the Independent Team suggests that a prototype could be implemented within four weeks of the publication of this report, with the final model being agreed within six months of publication.

Recommendation 6: Nottinghamshire Healthcare NHS T following its own internal investigation recommended that:

"Where possible, partner agencies should be engaged and agree to be involved in similar processes to ensure that the lessons learned can be shared to ensure ongoing improvements in the care of individuals whom they deliver services to."
This recommendation has not been delivered. Although the principle of the recommend was and remains appropriate, the way it has been formulated will make it challenging to deliver. Consequently the Independent Team recommends that:

- A senior Manager in each directorate is given the express responsibility for liaising with third party agencies to seek their cooperation with the internal review of serious adverse incidents where the third party has been involved with the service user, and their involvement is considered necessary.
- An executive director of the Trust is also identified as the lead executive for engaging with his/her counterpart in the involved partner agency. It is essential that the initiation to participate is initially made at this level in the organisation, especially following incidents of the magnitude of the Mr S case.
- The Trust develop a template letter that can be used by the Trust's internal investigation teams for the purpose of communicating with partner agencies following serious adverse incidents.

Target Audience

The Medical Director and Head of Integrated Governance and Performance.

Timescales

The Independent Team suggests that this recommendation is addressed alongside recommendations four and five.

Recommendation 7: The Housing Provider needs to reiterate to all relevant staff the importance of documenting significant communications about individual tenants with partner agencies such as mental health services.
With the increase emphasis on the independent review process following mental health homicide, domestic homicide, and the serious case review process for children and vulnerable adults it is important that housing officers understand that attention to detail in their written records is increasingly important.
When communicating with mental health services important information to record is: i) the reason for the communication; ii) what the context of the communication was; and iii) what the outcome of the communication was.

Target Audience: The Company Secretary for the housing provider concerned.

1.0 INTRODUCTION

Consequence UK Ltd (CUK) was commissioned by NHS Midlands and East Strategic Health Authority to undertake an independent review of the care and treatment of Mr S, who admitted to the unlawful killing of a man known to him.

Because at the time of the incident Mr S was a patient of the mental health service provided by Nottinghamshire Healthcare NHS Trust, the incident fell within the health circular guidance HSG (94)27. This guidance requires that in such circumstances there is an independent analysis of the care and treatment provided to the service user by mental health services to determine:

- its reasonableness;
- whether or not the incident as it occurred was predictable by mental health services; and
- whether or not the incident as it occurred was preventable by different care and treatment of the service user.

In addition to the above, it is expected that the retrospective analysis will be proportionate and not unnecessarily repeat elements of the Trust's own internal investigation where the Independent Team assessed this to be of a reasonable standard and meeting the local and national expectations of a serious untoward incident investigation, in particular the application of systems analysis where significant lapses in care and/or treatment have been identified.

Because the internal investigation report provided to NHS Midlands and East seemed to be comprehensive, it was decided that a proportionate approach to this investigation process would be to conduct an initial assessment of Mr S's clinical records across the three-and-a-half-year period prior to the incident, and then to follow this with an analysis of the Trust's own internal investigation report to determine to what extent it had explored the issues the Independent Team considered to be of importance.

It was agreed between the SHA and the Independent Team that, following this activity, the Independent Team would advise the SHA regarding further steps required, if any.

In February 2012, following the individual analysis of Mr S's clinical records by each member of the Independent Team, NHS Midlands and East were advised that, although the overall care and treatment of Mr S met with the expected local and national standards, and in part exceeded these, there were a small number of issues that required further exploration and analysis. The issues were highlighted to the SHA and a targeted investigation approach agreed upon. This consisted of:

- a round-the-table multi-professionals meeting with the clinicians involved in the direct care and treatment of Mr S;
- a meeting with Mr S's housing provider;
- the request for information from Nottinghamshire Police; and

- the request for information from Mr S's current forensic consultant psychiatrist.

The engagement of Mr S's sister as an active participant in the investigation process was also considered to be essential to fully understanding the changes in Mr S's behaviour in the nine months preceding the incident, which became known to mental health services only after Mr S's arrest.

This report therefore sets out:

- An overview of Mr S's contact with mental health services and his forensic/criminal history.
- The agreed terms of reference for the Independent Team.
- The findings of the Independent Team analysis of Mr S's clinical records and Nottinghamshire Healthcare NHS Trust's internal investigation report.
- The conclusions and recommendations of the Independent Team.

2.0 AN OVERVIEW OF MR S's CONTACT WITH MENTAL HEALTH SERVICES

2.1 Mr S's past psychiatric history (1994 – 2005)

Mr S first came into contact with mental health services in Scotland. Prior to Mr S's admission into hospital, he had reported hearing voices. Following admission, he:

- Absconded from the mental health unit; and
- Assaulted a nurse.

This led to his spending some time in a high-secure mental health hospital. It was during this period that Mr S was diagnosed with paranoid schizophrenia.

In 1995 Mr S was transferred from the high-secure services to the mental health service in Nottingham.

At the time of transfer, Mr S's medication comprised oral medication and long-acting 'depot' injections of Flupenthixol Deconate.

Following his discharge into the community, Mr S was managed successfully in the community with regular 'depot' injections until 1998, when a reduction in the dosage of his medication led to a deterioration in his mental health. During this period of deterioration, Mr S attacked his brother with a knife. No charges were brought against him following this.

Mr S's medication was increased and consequently, between mid-1998 and 2001, he remained stable in the community.

After September 2001 Mr S was noted to have become preoccupied with terrorist attacks. He became threatening to his family and is reported to have taken to carrying a knife around with him. By 2002 his behaviours had become overwhelming for his family and mental health services were alerted to a range of high-risk behaviours Mr S was exhibiting.

As a consequence of the deterioration in Mr S's mental state, he was admitted to a Psychiatric Intensive Care Unit on 23 August 2002, where he remained until January 2003.

During this admission, Mr S revealed that:

- he had a microphone in his throat;
- he had a transmitter in his bowels;
- there was a war going on between Scotland and Ireland against the English;
- he would lose his soul and go to hell if he did not fight the English.

When Mr S was discharged back into the care of consultant [1], he was on enhanced CPA and also had a care co-ordinator, in addition to his consultant. He remained

stable in the community, complying with his treatment regime of fortnightly depot injections of 100mg Depixol. However, in 2004 he grievously wounded a neighbour following an incident he found provocative. Mr S was sentenced in January 2005 to three-and-a-half years in prison. He was released back into the community in June 2006.

2.2 Overview of Mr S's contacts with mental health services in Nottingham during the three-and-a-half years leading to the incident.

Mr S was released back into the care of consultant [1] in July 2006 on standard CPA.

His first face-to-face appointment with consultant [1] was on 29 June 2006, which he attended with his sister. The plan at this time was for Mr S to attend at outpatient appointments with consultant [1] and to attend for his Depixol 100mg medication by injection every other week.

Mr S was reliable in attending for his medication for the entire three-and-a-half years (June 2006 – 24 December 2009). He was not, however, very reliable at attending for his outpatient appointments.

Between July 2006 and December 2009 Mr S was offered 13 outpatient appointments, of which he attended four. On each of the appointments he attended, his sister was present with him.

Throughout the three-and-a-half years after his release back into the community, Mr S presented as well, and although his voices were noted to remain present from time to time, Mr S reported that, with his medication, he was managing these. The 'depot' clinical records show that at no time did any member of staff identify any signs of mental ill health in Mr S. Furthermore, at not one of the outpatient appointments that Mr S attended with his sister did she raise any concerns about her brother's behaviour.

The only factor of note between 2006 and 2010 was the reconfiguration of mental health services across Nottinghamshire which required Mr S to change community mental health teams and therefore his long-standing consultant psychiatrist (consultant [1]). The manner with which this transition was managed by the community mental health team staff involved was exemplary, and there is no discernible difference in Mr S's pattern of engagement/non-engagement with outpatient appointments pre or post his transfer to a city-based community mental health team.

Mr S's last outpatient appointment was on 21 December 2009, where he was assessed by a locum consultant psychiatrist. The records of this assessment raise no concern about Mr S's presentation and the plan regarding his management remained unchanged.

Mr S's last depot injections were on 7 and 24 December respectively. Again, the staff involved did not detect anything of concern about Mr S's presentation and he revealed nothing to them that could have alerted them to any deterioration in his mental state.

The incidents that occurred in the days leading to the incident appear to have come ‘out of the blue’ to Mr S’s sister and to the mental health professionals. However, at the time of Mr S’s arrest, it came to light that Mr S’s housing provider had been concerned about Mr S’s behaviour in March 2009, and again in November 2009. However, the CMHT to which Mr S was attached was unaware of the incidents giving rise to this.

3.0 TERMS OF REFERENCE

The terms of reference for this HSG (94)27 investigation were as follows:

To undertake a validation review of the internal investigation report provided by Nottinghamshire Healthcare NHS Trust into the care and treatment provided by them to Mr S.

The Independent Team was asked to:

- Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.
- Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.
- Assess whether the analysis undertaken is reasonable and proportionate and accurately reflects the issues identified with the quality of health and social care provided to Mr S. (This includes an assessment of Mr S's care and treatment by the mental health service).
- Review the Trust's policies and procedures to validate their compliance and that this was accurately reflected in the internal investigation report, paying particular attention to:
    - The Care Programme Approach;
    - The risk assessment process;
    - Care plans; and
    - The Mental Health Act assessment.
- To establish whether the recommendations identified in the Trust's internal investigation report are appropriate and would mitigate against the issues identified.
- To identify any additional learning from this investigation through applying root-cause analysis tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority, now NHS Midlands and East.

4.0 CONTACT WITH Mr S AND HIS FAMILY

It is customary when conducting this type of investigation that the service user, his/her family and the family of the victim are invited to meet with the Independent Team and Strategic Health Authority to talk through the process of the investigation, its boundaries and to determine what if any questions the families and/or the service user have.

The strategic health authority wrote to the sister of Mr S on the following dates:

- 30 September 2011
- 15 November 2011
- 7 December 2011
- 10 January 2011

No response was received to any of these communications. Consequently, on 9 March 2012 the Independent Team contacted Mr S's current consultant psychiatrist and highlighted that communication with Mr S's sister would be valuable. Subsequent to this, a message was left for Mr S's social worker to make contact with the Independent Team with the express purpose of achieving successful contact with his sister. At the same time, a further letter was sent to Mr S's sister by the Independent Team, seeking her support and input with the investigation. This correspondence did generate a response from Mr S's sister. As a result, she and the Independent Team had a lengthy telephone conversation on 26 April, and a face-to-face meeting was arranged for 10 May.

With regards to Mr S himself, correspondence was sent to him in early October 2011. On 12 October Mr S responded, advising the Independent Team that he did not wish to meet, but that he would welcome a copy of the report when it was ready for publication. Mr S also provided the Independent Team with his consent for it to access his personal mental health, housing and police records where considered relevant to do so in the conduct of the investigation.

Mr S's current clinical team were also provided with a copy of the Independent Report in draft format prior to publication so that they could inform Mr S regarding its content and support him in obtaining independent legal advice if he wished.

5.0 FINDINGS OF THE INDEPENDENT TEAM

To deliver the terms of reference for this HSG investigation, the Independent Team undertook a detailed analysis of Mr S's clinical records between his discharge from prison in 2006 to the date of the incident in January 2012. The investigation tool used to support this analysis was a structured analytical timeline. The replication of Mr S's chronology using this tool enabled the Independent Team to forensically examine the care and treatment provided to Mr S by the specialist mental health services provided by Nottinghamshire Healthcare NHS Trust.

In addition to its analysis of Mr S's clinical records, the Independent Team also had access to:

- The written interview records made by the Trust's own internal investigation team, which related to the following staff:
  - Mr S's care co-ordinator prior to his arrest for the assault he conducted in 2004.
  - The clinical director for adult services in 2010.
  - The CPN tasked with supporting the transfer of service users between the county and city CMHT's following the service reconfiguration.
  - Mr S's consultant psychiatrist 2002 – 2009.
  - The consultant psychiatrist who met with and assessed Mr S on 21 December 2009.
  - One of the depot clinic nurses at the base clinic attached to the city community mental health team.
  - The consultant forensic psychiatrist who assessed Mr S after the incident.
- Nottinghamshire Healthcare Trust's CPA and risk assessment policies.
- Information from Mr S's housing provider.
- Nottinghamshire Healthcare's own internal investigation report.
- The Pre-sentencing Psychiatric Report requested by the Crown Prosecution Service dated 23 August 2010.

As a consequence of its analysis of all of the above, the Independent Team was unanimous in its conclusion that there is no substantial reason to conduct a full independent investigation of Mr S's mental health care and treatment prior to his index offence.

The rationale for this conclusion was four-fold:

Firstly, the Independent Team could identify no single episode where any of the mental health professionals involved in the care and treatment of Mr S lapsed in their professional conduct or in the delivery of their care and treatment of Mr S. To the contrary, the clinical records consistently show that a good standard of care was provided to Mr S.

Secondly, Mr S was 100% compliant with his medication and there was nothing in his presentation that suggested that he was experiencing active psychotic phenomena at any time in the pre-incident period. Mr S's sister has reported that he was unwell in that he had lost a considerable amount of weight and that this had been commented on by some of the staff at the depot clinic; but she also confirmed that even she had not detected anything that might have alerted mental health services to the sequence of events that occurred.

Thirdly, on 21 December 2009 (seventeen days prior to the incident occurring) Mr S was assessed by a consultant psychiatrist. Mr S was accompanied by his sister at this visit. No signs of psychosis were identified by the assessing clinician. At his interview during the Trust's internal investigation, this professional also reported that neither Mr S nor his sister provided any information suggesting otherwise.

Fourthly, in the immediate aftermath of the incident, Mr S's clinical records clearly note that his sister was at a loss to identify what had triggered the series of events leading to her brother's death.

5.1 Information detailed within Mr S's clinical records that show he was provided with a reasonable standard of care

The Independent Team considers that the following demonstrates that a good standard of care was provided to Mr S:

- The letters from consultant [1] to Mr S when he did not attend at outpatient appointments were warm and engaging. This approach can make the difference between a service user attending at the next outpatient appointment or not.
- The efforts made to support Mr S in the transfer of his care from his county consultant, consultant [1], to his new city community mental health team. These efforts included:
    - A discussion between consultant [1], Mr S and his sister in February 2008 about this issue and why it was necessary.
    - The allocation of an experienced CPN, already working with the team, to specifically support the smooth and safe transfer of patients as required by the reconfiguration of the mental health services in Nottinghamshire. This individual specifically focused on those service users for whom the change would be most unsettling to, or who were resistant to, the change. Mr S was identified as such a service user.
    - The maintenance of Mr S's depot injections at the clinic base he was used to attending for as long as possible.

- Effective transfer of information between the city and county consultants about Mr S. This was in spite of the range of locum consultants who became involved in the process over a relatively short period of time.

- The clear communication between consultant [1] and the 'reallocation' CPN [2] on 20 February 2008 about Mr S and the need for continuity in his medication. This letter stated: *"It is essential that his medication is not changed in any way. When I reduced this eight years ago he became very psychotic and needed a long-term admission to the Forensic Unit."* Consultant [1], in this correspondence, also informed the 'reallocation' CPN that Mr S was concerned about the changes occurring in his care and that he *"does not use buses and only walks. With this in mind, it may be difficult for him to attend a Depot clinic on the other side of town."*

- The attention to detail by the 'reallocation' CPN. On 18 June 2008 she was concerned that she had not received notification of the rescheduled outpatient appointment for Mr S to meet with his new city consultant psychiatrist, (consultant [2]). She personally undertook the re-organisation of this, securing an appointment for Mr S with consultant [2] on 8 October 2008. This was six months after the original April date. This CPN also noted in her record that the appointment date would be sent to Mr S's sister and also copied to consultant [1] and the depot clinic Mr S had been attending, so that all were informed.

- On 20 June 2008 the reallocation CPN wrote a sensitive and informative letter to the sister of Mr S. The letter highlighted that she, the CPN, had met with Mr S and his sister earlier in the year, that Mr S had missed his outpatient appointment with consultant [2] in April, and that she had re-organised the appointment for 8 October with consultant [3] (a locum). The CPN also invited input from Mr S's sister regarding anything else she could do to help Mr S to keep his October appointment.

- The evidence of joint working between consultant [1], the reallocation CPN and consultant [3] to achieve the required transfer of care for Mr S. A specific example of this was following Mr S's non-attendance at his outpatient appointment in October 2008. On 8 October 2008 consultant psychiatrist [3] (a locum) wrote to consultant psychiatrist [1], highlighting Mr S's non-attendance at his outpatient appointments in April and October. As a consequence of this, consultant [3] wrote, *"In the circumstances, and after*

[2] This CPN was already employed by the city community mental health team. The team had decided that, during the period where patients were being transferred from the county community teams to the city team, it was prudent to allocate dedicated resources to assisting in the safe transfer of these patients.

discussion with [*the reallocation CPN*] *... we wonder whether one way forward might be to set a discharge date from your end for a month or two's time with myself perhaps jointly seeing* [*Mr S*] *with yourself at* [*your clinic*] *in order to formalise the transfer of care."* The subsequent appointment made for Mr S to meet with consultant [1] at his usual clinic on 9 December shows that consultant [1] was able to support the proposal made.

- The effective utilisation of the depot clinic staff to try and encourage Mr S to rearrange missed outpatient appointments. On 30 October 2009 the nursing records recorded: *"Discussed with* [*Mr S*]*, re the above entry* [*this set out the discussion at the Multi-disciplinary team meeting, about Mr S's non-attendance at outpatient appointments*]*."* Mr S reported that he had no knowledge of his outpatient appointments as he could not read and therefore relied on his sister to inform him of letters and appointments. A consequence of this exchange was the instruction by the senior practitioner (CPN) that a double check should be made to see if Mr S had made a new outpatient appointment as instructed. If not, one should be made for him and information sent to his sister about this. On 2 November 2009 the CPN records say: *"OPA visit already booked on Rio for 21 December 2009 at 4.30pm. ... Letter written to sister and sent – see correspondence" (*reallocation CPN).
- The clear accommodation of difficulties Mr S's sister sometimes encountered in bringing Mr S to the depot clinic as a consequence of her own work. The clinical record of 20 August 2009 clearly shows that Mr S's sister was reassured that if there was future difficulty with transporting Mr S to the clinic she could call and rearrange the appointment to better suit her availability.

5.2 Aspects of Mr S's care and treatment that could and should have been presented in more detail in Nottinghamshire Healthcare's internal investigation report

Although the Independent Team found the overall care and treatment of Mr S to be good, following its analysis of all of the information available to it, it did identify a number of issues that should have received specific attention within the Trust's report. These were:

- Mr S was placed on standard CPA when he was re-engaged with CMHT services following his discharge from prison in 2006. Prior to his custodial sentence in 2005, he had been on enhanced CPA. It was also noted by a prison in-reach CPN on 29 September 2005 that Mr S was to be seen in prison every *"2-3 weeks" "due to his CPA status and history/diagnosis of paranoid schizophrenia".* It is also recorded in Mr S's records on 14 March 2005 that his care co-ordinator was leaving the county community mental health team and that *"consultant [1] was to take over as the nominated worker".* The record also noted that Mr S may be facing up to *"seven years in prison".* The Independent Team notes that it is not unusual in such circumstances for the care co-ordination role to be passed to the responsible clinician. However, although his then consultant psychiatrist (consultant [1]) had a very good relationship with Mr S, and had a detailed understanding of his history, with the benefit of hindsight the decision to keep Mr S on standard CPA on discharge from prison may not have been the best judgement at that juncture in Mr S's care plan. This decision should have been explored at interview with consultant [1] by the Trust's own investigation team. The records made of this interview do not contain any information suggesting that this occurred. It was therefore an omission in the investigation process.

  The issues of CPA and Mr S are further addressed on page 37.

- The Trust's internal investigation team suggest in their report that Mr S had a CPN care co-ordinator. This is an inaccurate portrayal of the situation at the time. Consultant [1] was Mr S's care co-ordinator. An experienced CPN was appointed to support the transfer arrangements for Mr S, along with a range of other service users. She was not, however, Mr S's care co-ordinator. Her role was to support the safe and smooth transfer of county patients to the city service and vice versa, as dictated by the changing team boundaries as a consequence of the reconfiguration of services. The Independent Team does not wish to detract from the very good initiative instigated by the adult mental health services allocating a team member specifically to manage the transfer process, but it is important that the role of this CPN, and the boundaries of

that role, are not confused with that of a care co-ordinator allocated to enhanced CPA service users.

- Following Mr S's non-attendance at his first outpatient appointment with consultant [2] in 2008, the letter sent to the GP said that another appointment would be booked in *"due course".* By June this appointment had not been scheduled. This lapse was identified by the reallocation CPN, who was concerned because she had *"heard no news".* Although it is a testament to her role, and her execution of this role, that the lack of appointment was noted, the Trust's internal investigation team did not, in its report, reflect on how or why Mr S was not sent a new appointment direct from the outpatient clinic. This was a systems lapse that the Trust's investigation team should have commented on.

- The information gathered by the Trust's investigation team via staff interviews revealed that Mr S's family had previously had a high threshold for containing Mr S's risk behaviours before alerting mental health services about this. This information was shared by consultant [1]. In view of consultant [4]'s not unreasonable assumption that, if there were issues of concern, Mr S's sister would have informed mental health services about these, the Trust's internal investigation team should have explored as an essential component of its investigation:
    - What understanding the city community mental health team had regarding Mr S's family's high threshold of tolerance for some of his anti-social and risky behaviours.
    - What difference it would have made to their management of Mr S had they known this with regards to:
        - Their response to Mr S's non-attendance at outpatient appointments.
        - The level of reassurance obtained from family reports that there were no issues of concern.
        - Mr S's overall management plan, including his CPA level.

  It would also have been beneficial to the Trust's investigation team to have met with the sister of Mr S to achieve an accurate picture of her perspective regarding her brother in the weeks and months preceding the incident. However, the Independent Team recognises that this would have been difficult to have achieved because of the parallel criminal investigation being conducted.

  Notably, a conversation the Independent Team had with consultant [1] revealed that it was only after he became aware of the incident that he considered that he and his colleagues may have been over-reliant on Mr S's sister to inform them of any problems relating to Mr S's behaviour. Consultant [1] told the Independent Team that he believed that after the events of 2002,

which resulted in Mr S's admission to psychiatric intensive care for four months, the family, and in particular Mr S's sister, would be more forthcoming about any deterioration in her brother's behaviours. Consultant [1] also told the Independent Team that, with the benefit of hindsight, the containment by Mr S's family of his very risky behaviours in 2002 is something that should have been explicitly articulated, even though at the time he considered this problem to have been resolved.

The Independent Team considers that consultant [1]'s thinking and consideration about the past behaviour of Mr S's family was reasonable and it is possible that a number of consultant colleagues would have thought similarly, especially given the lapse of time between 2002 and 2010. Over the time period, excepting the offence leading to Mr S's custodial sentence in 2005, there had been nothing in his behaviours giving rise to the level of concern that had arisen in 2002 as far as the mental health services were aware of.

- On a number of occasions in the clinical records it is clearly documented that Mr S had a habit of throwing away correspondence without reading it. This was as a consequence of his reading difficulty. His sister was noted as the person to whom correspondence should be sent and she would make sure that Mr S was aware of it. The Trust's investigation team in their report do not articulate the reliability with which information was sent to Mr S's sister between 2008 and 2009. In the context of the frequency of Mr S's non-attendance at outpatient appointments, this was an important issue for the Trust's investigation team to have commented on. (The Independent Team notes that there is clear information in the nursing progress records that Mr S's sister was informed about her brother's outpatient appointment of 21 December 2009, and that Mr S did attend at this appointment, accompanied by his sister.)

The next section of this report sets out the Independent Team's findings in relation to the specific terms of reference agreed with East Midlands SHA.

5.3 The Independent Team's findings in relation to the Terms of Reference set by NHS Midlands and East

5.3.1 Term of reference 1

Establish whether the timeline was accurate and all-encompassing, ensuring that the Trust has considered all the relevant evidence; for example, Trust documentation, key witness statements and interviews.

The Trust's investigation team set out Mr S's chronology in a narrative format under the following headings:

- Background
- Forensic History
- Psychiatric History
- Incident Details.

The Independent Team found that the chronology presented was complete in relation to:

- Background
- Forensic History
- Incident Details.

Furthermore, the summary style adopted by the Trust's investigation was a reasonable one considering the length of time in advance of the incident the chronology related to.

With respect to the chronology as presented under the heading *Psychiatric History*, this was also presented as a summary of Mr S's contacts with mental health services. Although this can be considered reasonable up to and including Mr S's custodial sentence in 2005, after his release from prison in 2006 the Trust's investigation report should have set out the chronology of Mr S's contacts with Nottinghamshire Healthcare NHS Trust in much more detail than it did.

The chronology presented in the Trust's report contained a small number of inconsistencies between what was recorded in the clinical record and what was set out in the report.

These anomalies were:

- The reference to Mr S having the reallocation CPN as a care co-ordinator, which this report has already made reference to.
- That Mr S attended at his outpatient appointment of October 2009, which he did not.

The Independent Team suggests that, had the Trust's investigation team used a structured timelining tool, then these anomalies could have been avoided.

Furthermore, it is the perspective of the Independent Team that, had such a tool been utilised, the detail of Mr S's contacts with the mental health service in Nottingham would have been stated more clearly and thus have been accessible to the reader of the report.

5.3.2 Term of reference 2

Undertake a scoping exercise to identify whether all necessary agencies have been considered and included in the internal investigation. Where this has not been the case, to assess whether the inclusion of the information into the timeline could affect the findings.

The relevant agencies in this case were:

- Nottinghamshire Healthcare NHS Trust;
- The housing provider for Mr S;
- Nottinghamshire police.

The housing provider

The Trust's investigation team did invite the housing provider to participate in the investigation process. The Independent Team understands that the clinical director of adult mental health county services contacted the Company Secretary and Solicitor for the housing provider to Mr S on 9 June 2010, alerting her to the internal investigation Nottinghamshire Healthcare NHS Trust were conducting and seeking information from the housing provider to assist with this. Correspondence was also sent to the housing provider's Company Secretary on 9 June, clarifying the information required.

The housing provider did respond to Nottinghamshire Healthcare NHS Trust on:

- 9 June 2010;
- 18 June 2010; and
- 21 June 2010.

The content of the 18 June and 21 June correspondence make clear that the housing provider was willing to assist in the provision of information in so far as the impending criminal justice procedures allowed. At the time the request for information was made, Mr S remained in custody and his case had not been heard and therefore no judgement regarding conviction had been made. That the case of Mr S had yet to be heard in court was a significant impediment for the housing provider in relation to its active participation in the Trust's internal investigation. The Independent Team understands, following a meeting with the housing provider, that it did contact the Crown Prosecution team and they were informed that they should not attend at the meeting proposed by the Trust.

The correspondence viewed by the Independent Team suggests that the Trust's internal investigation team wanted to know about the housing provider's experience of information-sharing with the Trust. In its correspondence of 18 June 2010, the housing provider informed Nottinghamshire Healthcare NHS Trust that:

"To my knowledge and from the Company's perspective, the Trust does not share information with the Company unless an assigned health professional has been nominated to act on behalf of the tenant or the tenant formally gives notice of their representative health professional (or other representative)."

The housing provider also informed Nottinghamshire Healthcare NHS Trust that:

"if there are any concerns regarding a tenant, then dependent upon the nature of those concerns, the matter is either referred to the Police or to the Vulnerable Persons Panel ('VPP'). The VPP is a multi-agency panel, but to my knowledge, there is no nominated officer or representative from the Adult Mental Health Team."

The investigation report compiled by the Nottinghamshire Healthcare NHS Trust's investigation team did not include the above information in its investigation report. Neither did it include any information to suggest that it had considered whether or not the Trust had any duty to inform the housing provider of its involvement with Mr S.

In light of the behaviours attributed to Mr S between March 2009 and 2010, the Independent Team suggests that the whole issue of communication with other partner agencies could and should have been afforded a greater level of attention in the Trust's investigation report.

As a consequence of the inability of the Trust's internal investigation team and the housing provider to openly communicate because of the impending Crown Prosecution case, the Independent Team contacted the housing provider during its review and sought answers to the following questions:

- *When Mr S was offered a tenancy with* [*the housing provider*]*, was it aware that he had a mental health history and was in receipt of secondary mental health services?*
- *Where* [*the housing provider*] *is aware that a tenant is in receipt of mental health services from Nottinghamshire Healthcare NHS Trust, what is the policy of* [*the housing provider*] *regarding communications with the mental health provider?*
- *Where it is known that a tenant is in contact with mental health services, and there is a marked deterioration of the behaviour of that tenant that is brought to the attention of* [*the housing provider*]*, what is the expectation regarding the proactive communication between* [*the housing provider*] *and the mental health service?*
- *Does* [*the housing provider*] *have a consent process whereby its tenants can provide permission for* [*the housing provider*] *to communicate relevantly with other agencies involved with the tenant?*

- *How do the housing managers representing* [*the housing provider*] *understand the need to communicate with other involved agencies where there are identifiable risks to public safety?*
- *The housing manager made a Safeguarding Referral to the Vulnerable Adults Team around April 2009. How was this referral assessed, and to what extent was relevant information gathered from other agencies involved with Mr S? Particularly, what was the rationale of the Vulnerable Adults Team for not progressing the referral made by the housing officer?*
- *How did the manager on know to contact the* [*relevant*] *community mental health team directly on Mr S's arrest?*
- *If the housing manager knew how to contact the* [*relevant*] *community mental health team prior to 2010, and knew that Mr S was receiving a service from them, why did she not contact them at any time prior to 2010? (This it transpired was an unnecessary question.)*
- *If a tenant is on 'enhanced CPA' (now just CPA), is it usual practice, as far as you, or the housing officers know, for the relevant housing officer to be invited to the six-monthly CPA multi-professional, multi-agency meetings, and/or to be invited to send a report into the relevant care co-ordinator about any issues of concern in the community? (Mr S was on standard CPA, but had he been on enhanced, I am wondering to what extent mental health services would have proactively included your service in the regular review processes.)*

When the Independent Team met with the housing provider, it became clear that not all of the above questions were relevant to Mr S's situation. Mr S was a private tenant of the housing provider and was not in receipt of supported accommodation; because of this, Mr S was entitled to all confidentialities afforded any private tenant. Consequently, the housing provider was reliant on Mr S and his sister for the depth of information they held about him.

The following information sets out issues of relevance to the terms of reference of this independent investigation.

The Independent Team understands that the housing provider was aware that Mr S was in contact with mental health services and to their understanding had a community psychiatric nurse. However, the housing provider was not provided with any specific contact details for Mr S's mental health team.

At the time the Independent Team met with the housing provider, they were not able to double check their 2006 records to determine whether or not the letter written to them supporting a change in housing provision by Mr S's consultant psychiatrist had been received, and if so, whether or not the specific information provided regarding Mr S's vulnerability and diagnosis had been noted. The Independent Team asked Nottinghamshire Police if they would check the housing records they had obtained as part of the criminal investigation. The police were able to confirm that the letter from consultant [1] was not contained within the records relating to Mr S's address at the time of Mr S's arrest.

With regards to effective communication with partner agencies, including mental health, the Independent Team understands that this can be challenging for a housing provider, particularly where the tenant is a 'private tenant'. For the provider in question the staff member in Mr S's area of residence was responsible for 600 tenancies. Furthermore locality based staff are not professionally qualified and are relatively junior members of staff. Nevertheless, if staff are concerned about a tenant, it is the experience of the housing provider that, they do try and raise concerns. In the case of Mr S, the staff member is reported to have:

- Contacted mental health services in March 2009 to find out if Mr S was receiving care and treatment and from whom;
- Made a vulnerable persons panel referral on 18 March 2009 so that Mr S's case could be considered on a multi-agency basis because there was concern about him.

Both actions were reasonable actions to have taken.

The Independent Team was advised by the in-house solicitor for the housing provider that its staff member was informed by mental health services that Mr S was not in receipt of any service. Although the staff member reported that she would normally have made a record of this communication with mental health services on this occasion she did not. She recalled:

- That it was her normal practice at the time to provide the tenants personal details, this usually included the name, date of birth, and address.
- Contacting the specific locality within mental health services because there were other tenants in the area who attended there.

The Independent Team sought to achieve validation of the information by having the March and April 2009 duty diaries for the locality contacted reviewed for any notation of the contact made. A number of entries were identified as arising from the housing provider but not in relation to Mr S.

The Independent Team has no reason to doubt the report made by the housing providers employee; and it would seem that mental health services also lapsed in relation to making a record of the call. The Independent Team is reassured by mental health services that it was and is normal practice to make a record of calls pertaining to concerns about service users and that it was also normal practice to check on the patient registration system which team a service user belonged with and to direct the caller accordingly.

The lack of documentation relating to this episode highlights the absolute importance of good documentation by all agencies when communications between them occur.

Regardless of the lack of contemporaneous documentation in this case, that the housing providers employee was not able to speak with the community mental health team responsible for Mr S represented a lost opportunity for a detailed assessment of him, and also a lost opportunity for mental health services to have learnt of behaviours that would have resulted in Mr S being moved from standard CPA to enhanced CPA.

The material difference this would have made was the allocation of a non-medical care co-ordinator and enhanced monitoring of him, including a greater likelihood of home visits when he did not attend at outpatient appointments.

The concerns at the time were a range of anti-social behaviour and graffiti incidents within the housing estate. Mr S was thought to have been involved in the graffiti, the content of which was considered by mental health services to constitute signs of relapse. However the housing provider did not at the timer suspect Mr S of the other incidents of anti-social behaviour.

In addition to the above, had Mr S's community mental health team been aware, they could have elected to attend at the Vulnerable Persons Panel, although at the time mental health services were not regular attenders at this and retrospectively one cannot say with any confidence that a team member would have attended at this panel.

As it transpired, the outcome of the panel meeting for Mr S was a bringing forward of the routine welfare check that would have been made by the housing provider in a further 18 months. The welfare check was considered to be a useful vehicle to enable contact between the local beat officer (a police officer), the housing provider and Mr S. Mr S was not at his home when the first visit was made. When there was no response to the calling card left for him, a second visit was made and successfully concluded. The housing provider was informed by the beat officer that, as a consequence of the home visit, no further action was required by them.

With regards to third-party information sharing, the housing provider informed the Independent Team that it is standard practice for them to seek consent from a tenant to share information on a relevant basis with partner agencies. The Independent Team is satisfied that the housing provider is committed to the principle of information sharing and demonstrated involvement in a range of activities that showed that it does share information.

After the incident, when the housing provider contacted mental health services, they placed their call to the adult services access team. It was coincidental that the duty worker taking the call happened to be the senior practitioner for the community mental health team that Mr S was assigned to.

With regards to the Care Programme Approach (CPA), the individuals representing the housing provider had never heard of it and were not aware of their workers being invited to CPA meetings. Because none of the working-age tenants are in supported living accommodation, the Independent Team found it understandable that the housing provider had not been invited to CPA meetings. It would not be reasonable for them to be invited unless the service user him or herself initiated this.

5.3.2.1 Nottinghamshire Police

Nottinghamshire Police were not invited to participate in the Trust's internal investigation process. At the time the Trust's investigation took place, the Independent Team considers that police participation would not have been appropriate because of the criminal justice investigation being undertaken in respect of the charge of murder against Mr S.

However, now that Mr S's case has been determined by the courts, the Independent Team sought relevant information from Nottinghamshire police in respect of its interface with mental health services when a known mental health service user with a marked forensic history is arrested, as Mr S was in November 2009.

The Independent Team was informed by the Detective Inspector that it met with that when Mr S was arrested in November 2009 there was no evidence that his behaviours were triggered by mental health issues. The Independent Team was also informed by Mr S's sister that there had been a disagreement between her brother and the shop keeper. It was not, she considered, out of the ordinary for her brother to have lost his temper in the way that he did when he damaged the shop.

The Detective Inspector was also able to confirm for the Independent Team that there was no mental health marker on the Police National Computer (PNC) for Mr S.

Both the Detective Inspector and the Independent Team considered that a mental health marker on the PNC would have been appropriate. Had there been such a marker the likelihood of communication occurring between the police and mental health services at the time of the November incident would have been greatly increased.

5.3.3 Terms of reference 3

Assess whether the analysis undertaken is reasonable and proportionate and accurately reflects the issues identified with the quality of health and social care provided to Mr S.

It is the contention of the Independent Team that the whole purpose of a retrospective investigation following serious incidents such as this one is to conduct a detailed analysis of the service user's care and treatment to determine the extent to which the care and treatment provided met with expected standards, and whether there were any lapses in the standard of service and care provided.

In mental health services there is a generalised expectation that core components of this analysis will be careful consideration of:

- Adherence to key policies and procedures such as CPA and Risk Assessment.
- The care planning for the service user, including his/her CPA level.
- The robustness of risk assessments, including the clarity of relapse indicators and the contingency management plan.
- Family involvement.
- Medication management.
- Inter-agency communications and the effectiveness of inter-agency working relationships.

The Trust's investigation team in their report set out a number of key questions it considered to answer. These questions were:

- *Was the level of care that was provided appropriate?*
- *Were outpatient follow-up CPN/Depot and clinic attendance adequate?*
- *Were Assertive Outreach or Community Forensic services relevant?*
- *Was the transfer from county to city clinical teams dealt with appropriately and safely?*
- *Why was a transfer between teams deemed necessary and was there an alternative?*
- *Was there a clinical history or signs or symptoms missed in the run-up to the incident?*
- *Was the induction of new staff adequate?*
- *The panel also attempted to address the question of what information was shared between the housing provider and Nottinghamshire Healthcare Trust.*

These questions the Trust's investigation team considered were those necessary to deliver the terms of reference provided to it by the Trust's Executive Director for Local Services. These terms of reference were:

"1.2.1 The quality and scope of all Health Services provided in the care of Mr S prior to the incident in 2010.

1.2.2 The availability of local and specialist services to meet his assessed and social care needs.

1.2.3 The extent to which care and support corresponded with statutory obligations, relevant Department of Health Guidance and operational policies and procedures. This should include a review of the professional judgements made and what indicators were used to assess risk, what protocols were in place for risk assessment and how they were used and documented.

1.2.4 To examine the adequacy of the collaboration and communication between the professional groups involved, both within the Trust and the wider healthcare community, e.g. GP.

1.2.5 To review the risk assessment process whilst the patient was under the care of Trust Services as well as care planning, communication and review processes, e.g. CPA, and to confirm that there was effective communication with the patient's GP.

1.2.6 To identify and explore any possible vulnerable adults issues.

1.2.7 To confirm the support arrangement for the families of both the victim/s and the perpetrator.

1.2.8 To work closely with Nottinghamshire Police to ensure that the Trust investigation does not overlap or otherwise conflict with the criminal investigation being undertaken (via the Trust Risk Manager).

1.2.9 To prepare a report on the investigator's findings, and make recommendations as appropriate, using a Root-Cause Analysis approach. The report will be considered by Local Services Serious Clinical Incident Review Group and the Strategic Health Authority.

1.2.10 To ensure the report is made available to Executive Director, Local Services and Adult Mental Health City for wider debate and action planning.

1.2.11 To review progress made into the implementation of the investigator's recommendations against any agreed action plan."

The Independent Team agrees that the specific questions identified by the Trust's investigation team were relevant, and if explored thoroughly would have delivered the terms of reference 1.2.1 through to 1.2.5 above. On the basis of its analysis of Mr S's clinical records, the Independent Team can see no relevance in this case with regards to vulnerable adults.

To determine the reasonableness of the analysis conducted by the Trust's investigation team, the Independent Team has set out its findings against each of the questions the Trust's investigation team set out to answer.

Trust investigation team question 1: Was the level of the care that was provided appropriate?

The information set out in the Trust's investigation report in response to this question is not as detailed as one would expect following the gravity of this incident, although the Independent Team agrees with the Trust's team that:

- Mr S's care and treatment prior to his custodial sentence in 2005 was appropriate.
- There was an appropriate risk assessment undertaken when Mr S's care and treatment was transferred from county to city services.
- There was appropriate consideration of where the best place was for Mr S to receive his fortnightly depot injection when he was transferred to the city CMHT. A key component of these considerations was not only ease of access for Mr S but also his sister, who was a key support person in Mr S reliably accessing mental health services.
- Mr S attended for his depot injections on a reliable basis.
- There were no indications that Mr S required the input of either assertive outreach or forensic services at any time between 2006 and January 2007.

The gaps in the information presented in the Trust's investigation report were as follows:

- **Quality of discharge from prison services:** There was no reflection on the quality of discharge from prison health services back to the county community mental health team. This was a critical step in the antecedent chronology and attention should have been given to this during the Trust's investigation and also in its report. Mr S's clinical records, in the opinion of the Independent Team, do demonstrate that the transfer of Mr S's care back to consultant [1] was conducted to the expected standard and the Independent Team has no concerns about this aspect of his care and treatment.
- **Mr S's pre-prison care plan:** In the Trust's report it says: *"when he was discharged from prison it was recommended he go back to the original care plan and see Consultant [1] in outpatients' clinic".* This reflection was not accurate. Prior to his custodial sentence, Mr S was on enhanced CPA and was being seen by his care co-ordinator and consultant [1]. It appears that during his period of time in prison Mr S's care co-ordinator left the community mental health team he had been working with. This professional's clinical record of 14 March 2005 made clear that care co-ordination responsibility was passed to consultant [1]. The clinical record also makes clear that at the time it was written the length of custodial sentence for Mr S had yet to be determined and could have been for as long as seven years. Mr S's mental health needs were attended to by the prison in-reach team during his period of time in prison. It is the understanding of the Independent Team that Mr S was placed on standard CPA while in prison as he was medication compliant and apparently well. The reasonableness of maintaining Mr S on standard CPA once he had been released from prison is something that needed to be determined.

- **CPA:** After some consideration, the Independent Team considers that it may have been prudent to have maintained Mr S on enhanced CPA and not standard CPA. His mental health diagnosis and his known high risk of harm to others when in relapse were, the Independent Team believes, sufficient indicators for this.

  The 1999 Department of Health guidance on the levels of CPA said that the characteristics of a person on standard CPA were:

  - they require the support or intervention of one agency or discipline, or they require only low-key support from more than one agency or discipline;
  - they are more able to self-manage their mental health problems;
  - they have an active informal support network;
  - they pose little danger to themselves or others;
  - they are more likely to maintain appropriate contact with services.

  The listed characteristics for enhanced CPA were:

  - they have multiple care needs, including housing, employment, etc, requiring inter-agency co-ordination;
  - they are only willing to co-operate with one professional or agency, but they have multiple care needs;
  - they may be in contact with a number of agencies (including the Criminal Justice System);
  - they are likely to require more frequent and intensive interventions, perhaps with medication management;
  - they are more likely to have mental health problems co-existing with other problems such as substance misuse.

  Mr S was well supported by his family, and at face value he only required the input of his consultant psychiatrist and the staff at the depot medication clinic. These factors would lead one to consider standard CPA for Mr S. However, he was also a person who:

  - could not manage his mental health problems; or
  - could not manage some of the necessities of everyday life, such as opening his post and responding to entreaties to contact the mental health service with regards to his outpatient appointments; and
  - did not tolerate change and was unwilling to positively engage in change.

  Mr S also posed a significant risk to others when unwell, though the Independent Team accepts that Mr S could pose a risk to others as a consequence of his historical behaviours, which are unrelated to his mental health disorder. However, the aforementioned factors, the Independent Team considers, were dominant factors and its consideration is that enhanced CPA would have been justifiable for Mr S.

Discussion between the Independent Team and the professionals who were involved with Mr S between 2006 and the time of the incident produced a vigorous debate around the CPA issue. A consequence of this was the acceptance by the Independent Team that with service users such as Mr S determining the level of CPA, although easy to determine retrospectively, would in most teams have generated mixed opinions and outcomes. The Independent Team therefore accepts that, although its clinical advisors believe that they would have opted for enhanced CPA, other teams would have opted for standard CPA, as Mr S's team did.

However, Mr S's mental health professionals were quite clear that, had they been aware of the possible involvement of Mr S in the range of incidents occurring in and around his housing estate in March 2009, and had they been aware of his arrest in November 2009, any one of those instances would have resulted in him being placed on enhanced CPA and enhanced monitoring of his mental state.

Had this occurred, Mr S's sister would have felt that she could have made contact with mental health services, as she did when consultant [1] and CPN [1] were involved with her brother. She had felt a loss of contact with the mental health service as a consequence of Mr S no longer having a non-medical care co-ordinator.

- **Risk Assessment:** Although there was comment on the risk assessment of Mr S, this was in the context of him receiving his depot injection from a new clinic that was not as well staffed as the one he attended in 'the county'. The Trust's investigation team did not comment on the completeness of the risk assessment, the risk management plan, or the contingency plan for Mr S based on its analysis of his clinical records and information gathered at interview.

  The Independent Team, on its review of the clinical records and its re-analysis of the interview records, noted that there were risk assessment documents completed on:

  - 21 January 2004
  - September 2005
  - 19 February 2008
  - 28 April 2009.

  There were also two Safeguarding Children Risk Assessments completed: one in June 2005 and one in March 2008. In March 2008 the assessment was incomplete because Mr S and his sister *"declined to complete"* it. Mr S's sister did not consider that her brother posed any risks to her children or his other nieces or nephews.

  There should have been a risk assessment for 2007. However, the Independent Team was not able to locate this in the records.

Of the above, the risk assessment of April 2009 was of most significance as it is the risk assessment of most relevance to Mr S's care and treatment. This assessment was appropriately completed and stated clearly Mr S's previous risk behaviours. The risk assessment also contextualises Mr S's risk history. It noted that Mr S *"had a history of anti-social behaviour since aged seventeen. More recently, any violent behaviour appears to be associated with mental ill health.* [*Mr S's*] *last violent incident happened in 2005 with no further episodes since.* [*Mr S*] *has presented no risk to staff who have come into contact with him on a fortnightly basis since 2006.* [*Mr S*] *has attended depot clinic since August 2005 until now with no incident."*

Mr S's relapse indicators were stated as:

> *"Definite increase in risk of violent behaviour when dose of medication has been reduced. Would be cause for concern if* [*Mr S*] *missed an injection.*
>
> *Relapse Indicators:*
>
> - *Poor sleep*
> - *Stops eating*
> - *Laughing and talking to himself*
> - *Argumentative*
> - *Paranoid delusions about family not being who they say they are."*

The risk assessment also says: *"all reports of interaction with* [*Mr S*] *over the past three years have shown no evidence of ill health or hostile behaviour".* It also says that Mr S was symptom-free and was well supported in the community and that, providing correspondence was sent to his sister, then she would ensure Mr S's attendance at outpatient appointments and at the depot clinic.

What was not in the risk assessment, but was articulated during interview by consultant [1] to the Trust's investigation team, was his experience that, although Mr S's family were very supportive and would bring matters of concern to the attention of mental health services, this could be quite late in the day. Mr S's family had a high tolerance for his risky behaviours, not always recognising when *"bad"* behaviours had become symptomatic of a deterioration of his mental health. The occasion that had led consultant [1] to this perspective was the significant delay in Mr S's family raising concerns in 2002 when Mr S's behaviour precipitated compulsory admission to hospital and admission to the psychiatric intensive care unit.

The significance of this information in relation to Mr S's care and treatment between 2006 and 2010 is not discussed in the Trust's investigation report. A subsequent discussion between consultant [1] and the Independent Team revealed that consultant [1] had believed that, following the events of 2002 and 2003, Mr S's family would have been more forthcoming with mental

health services if there were signs of any deterioration in Mr S's behaviours. It was only after the events of 2010 that consultant [1] realised that Mr S's family may have continued to have contained *"within the family"* Mr S's anti-social behaviour, not recognising that it may have been as a consequence of a deterioration in his mental health. With the benefit of hindsight, consultant [1] agreed with the Independent Team that it would have been prudent to have communicated the delay in Mr S's family raising the alarm regarding his past risky behaviours with the new city community mental health team.

The question this reflection raises is what difference this knowledge about the family would have made in terms of Mr S's management, particularly in 2008 and 2009, where Mr S was infrequently exposed to an assessment of his mental state owing to his non-attendance at outpatient appointments.

All persons present at the 'round-the-table' meeting conducted by the Independent Team agreed that there was an expectation that, should Mr S show signs reminiscent of his level of unwellness in 2002, then his sister would notify mental health services. All team members were aware that Mr S's sister was pivotal to his engagement with mental health services. On reflection, the mental health professionals considered that opportunity could have been provided for Mr S's sister to have spoken privately with a member of Mr S's team. However, even had this occurred the information provided to the Independent Team by Mr S's sister suggests that there were no incidents that she was aware of that indicated to her a deterioration in her brother's mental health state in the weeks and months leading to the incident between her brothers. Mr S's sister did perceive that her brother needed more support in the community than he was getting as he was losing weight and this concerned her, but, other than the incident with the shop keeper in November 2009 (an incident that she and her brother had spoken about and which he had explained to her), there was nothing notable that would have indicated to anyone the extent of Mr S's mental unwellness.

Trust investigation team question 2: Were the outpatient follow-up CPN/Depot and clinic attendance adequate?

The Trust's investigation team did not present the findings of their analysis in response to this question. However, it is clear from the Independent Team's analysis of Mr S's clinical records that Mr S attended reliably for his anti-psychotic medication as prescribed on a fortnightly basis. His last medication was on 24 December 2009. He was scheduled to attend again on the day of his arrest. The Independent Team has no concerns about the management of Mr S's medication and considers that the staff employed by Nottinghamshire Healthcare NHS Trust and Mr S's sister did all they could to ensure that Mr S received his medication without default, and that they were successful in achieving this.

With regards to Mr S's attendance at outpatient appointments, this was intermittent following his release from prison in 2006. The table below sets out his attendance rate:

Table 1: Mr S's attendance at outpatient appointments between June 2006 and December 2009

Date	Attended (√) /DNA (X)	Date	Attended (√) /DNA (X)	Date	Attended (√) /DNA (X)
29/6/06	√ (attended with sister)	26/4/07	X	9/12/08	X
25/7/06	X	No contact	April 07 – January 2008	9/3/09	√ (attended with sister)
10/11/06	X	16/2/08	√ (attended with sister)	July 2009	No evidence of appt. sent
4/1/07	X	11/3/08	X	5/10/09	X
14/3/07	X	20/6/08	Letter to Mr S's sister	2/11/09	Letter to Mr S's sister
26/3/07	X	8/10/08	X	21/12/09	√ (attended with sister)

The above table shows that Mr S attended at outpatients on four occasions between June 2006 and December 2009. The only year he received no medical assessment was in 2007. Although the Independent Team notes that consultant [1] asked Mr S to contact his secretary to arrange an outpatient to suit him, it also notes that there was no assertive outreach to Mr S over this period; for example, a home visit. Neither does there appear to have been any direct contact with Mr S's sister over this time to find out why Mr S was not attending at his appointments. Although the Department of Health's CPA Guidance document (1999) made clear that there was no longer a requirement for six-monthly reviews of a service user's care plans, there was an expectation that all service users on CPA would have a review on an annual basis. Consequently, it was incumbent on Nottinghamshire Healthcare NHS Trust to have made further assertive effort to engage with Mr S after 27 April 2007 and before 17 January 2008.

In the event, Mr S did attend at an outpatient appointment with consultant [1] in February 2008, as the table above shows. At this appointment Mr S was accompanied by his sister. The subsequent letter setting out the outcome of this appointment to Mr S's GP said:

"[Mr S] looked well having lost some weight. He has no psychotic phenomena and is Euthymic. He continues with his Depixol 100mg every two weeks and Procyclidine 5mg four times a day. ... His sister keeps a close eye on him and knows to contact us should there be any problems. As you know, [Mr S] struggles with his medical appointments and would prefer to be reviewed by yourself [i.e. the new consultant] *on a yearly basis. He is seen every two weeks in Depot clinic."*

The above was to have been Mr S's last outpatient appointment with consultant [1] as he had been *"re-sectorised to city X CMHT".* The letter from consultant [1] to the GP made clear that he had explained the re-sectorisation to Mr S and his sister and that he had not offered Mr S any further outpatient appointments, although he remained willing to see him should the occasion arise.

The Independent Team notes that, because of the transfer of Mr S's care and treatment to a city-based community mental health team, he continued to receive outpatient appointments. He would have required a medical assessment by his new consultant and thereafter on an annual basis in keeping with national CPA policy expectations. Although Mr S continued to not attend at many of the offered outpatient appointments (six in total), he did attend on at least an annual basis, which was in keeping with the minimum CPA requirements at the time, and now.

The Independent Team particularly wishes to note that Mr S's clinical records show that he was always offered an alternative appointment following non-attendance. His notes also show that, following his non-attendance in October 2009, the then city-based locum consultant psychiatrist sought the support of consultant [1] in trying to engage Mr S. Although it was not a successful strategy, the actions of the locum consultant demonstrated good practice.

The Independent Team also notes that between March and November 2009 there is nothing to show that any member of staff proactively contacted Mr S's sister to determine why Mr S was not attending at outpatient appointments. Given that all staff recall her being very supportive of her brother, the Independent Team considers that follow-up with her should have been an early consideration and acted upon following Mr S's non-attendance.

Trust investigation team question 3: Were Assertive Outreach or Community Forensic Services relevant?

This question was not addressed in the Trust's investigation report, even though the Trust's team had identified it as a specific issue to present. However, the Independent Team has found nothing in the clinical records to suggest that Mr S should have been under the care of either the Assertive Outreach team or the Forensic Service.

Mr S attended at all of his depot injection clinics, and whilst erratic with regards to outpatient appointments he did attend at least annually between 2008 and the end of 2009. He would not have met the entry requirements for the assertive outreach team.

With regards to care and treatment by a forensic team, although Mr S had a notable criminal history, not all of this was associated with deterioration in his mental health. Furthermore, it is not uncommon for a community mental health team to be managing service users with relatively high levels of risk, such as those posed by Mr S.

Trust investigation team question 4: Was the transfer from county to city clinical teams dealt with appropriately and safely?
The Trust's investigation reported that *"the transfer from the County to the City team was dealt with appropriately and safely".* It also noted that *"CPN [2]* [the re-allocation CPN] *had been appointed on a one-year secondment specifically to work with patients who were affected by the County/City transition.* [*Her*] *job was to make contact with the patients and carers attending outpatient and other appointments, working out what services were provided and how best to match those under the new arrangements."*

The Independent Team agrees completely with the Trust's investigation team that the transfer of Mr S was undertaken with due care and attention with a very good commitment to ensuring that the transition went as smoothly as possible for all concerned.

Trust investigation team question 5: Why was the transfer between teams necessary and was there an alternative?
The Independent Team is unclear as to why the Trust's investigation team posed this question. In any event, the Trust's team did not specifically address it in their investigation report. As the Independent Team understands it, there was a re-organisation of the services provided across Nottinghamshire to coincide with local authority and Primary Care Trust funding boundaries. This required the previous 'doughnut' shape to the city and county services to change to a 'wedge' shape. It is the understanding of the Independent Team that Nottinghamshire Healthcare NHS Trust did look at alternative solutions to the requirements of its purchasers, but that the only workable solution was to reconfigure all of the boundaries across adult services. This necessitated that Mr S move to a city-based community mental health team. In terms of 'exception management', the Independent Team understands that Mr S's needs were not notably different to those of other service users also affected by the change in boundary lines and thus it was appropriate that no exception was made to the move in his case.

Trust investigation team question 6: Were there aspects of clinical history, or clinical signs missed in the run-up to the incident?
The Independent Team has not been able to identify any lapse in the observation of Mr S by those staff who had contact with him in the period of time leading directly to the death of Mr S's brother.

Mr S was seen every two weeks at the depot clinic, and he was also seen by a consultant psychiatrist on 21 December 2009, three weeks prior to the incident. On this occasion Mr S was accompanied by his sister and neither Mr S nor his sister reported any concerns about him. Furthermore, on direct questioning Mr S was noted to report no psychotic symptoms.

The Trust's investigation team in their report say:

- Mr S missed only one appointment in the two years preceding the incident. This is not correct. Mr S was late for one appointment because his sister could not bring him on the required day.
- Mr S attended two outpatient appointments in 2009, one in October 2009 and one in December. This was incorrect. Mr S only attended on 21 December 2009.

With regards to the 21 December appointment, the Trust's report says the assessing consultants' assessment was:

"systematic and thorough, [*he*] *was particular to cover possible psychotic symptoms including delusions and hallucinations which he indicated were not present. He considered* [*Mr S's*] *mood disorder, stability and also asked about any thoughts of self-harm or wanting to harm others. ...* [*He*] *also discussed the issue with the patient's sister, who agreed that* [*Mr S's*] *mental state was satisfactory and that there were no concerns."*

The Trust's investigation team also reported that:

"the patient was looking after himself well and that the sister had reported that the first sign of any relapse was the patient became unable to care and look after himself adequately."

The Independent Team has found nothing to contradict the findings of the Trust's investigation team and concurs with its finding that, at the time of the assessment on 21 December 2009, the Trust's staff conducted a reasonable assessment and took in good faith the responses of both Mr S and his sister with regards to their reports of his seeming stability.

The pre-sentencing psychiatric report, which was prepared on 23 August 2010, revealed the following:

- That there was no evidence that Mr S had been using drugs and/or alcohol in the antecedent period leading to the death of his brother.
- That Mr S believed that he had a bugging device inside of him that had been put inside him when he was at HMP Lincoln.
- That Mr S believed that the bugging device had been planted *"to fight the other side of the world".* The report's author also recorded that Mr S told him that *"the SAS was fighting the other side of the world through him in order to gain control of heaven".* And that now his brother had died, *"it all finished".*
- That Mr S reported that *"it was either him or his brother, and his brother had to die, otherwise the conflict would carry on".* And that since his brother's death *"he hears only good voices".*

The pre-sentencing psychiatric report also set out that Mr S reported believing that:

- *"he was the chosen one and that members of the IRA had prayed for him to come down to earth in the 1950s and 60s before he was born"*;
- *"when he dies the aliens will come down and kill all the police and the army"*;
- *"his life was more or less over anyway after what had happened"*;
- *"no one else has to die now that his brother is dead ... we've won; that's it".*

Mr S was also reported as telling the assessing forensic psychiatrist (the author of the report) that the depot medication did nothing for him and that he was only telling him so much information *"because I'll probably never get out of jail"*. The report also noted that Mr S believed that *"no medicine will take away my voices and that the only thing that will take them away is an operation to remove the bugging device".*

The pre-sentencing psychiatric report also noted Mr S's report that he had told others about the voices he heard but that no-one believed him. The report also set out Mr S's recall of his last psychiatric assessment on 21 December 2009, at which he was accompanied by his sister. The report said:

"At the time he was hearing voice but it was 'no good telling people' as they simply would think he was mad."

The assessing psychiatrist's perspective as set out in the pre-sentencing report was that:

- Mr S was mentally unwell;
- On more than one occasion during the interview he clearly laughed in response to hearing something;
- Mr S's speech was normal, his mood appeared to be normal and reactive and there was no evidence that his thoughts were being blocked or interfered with in any way;
- The diagnosis of paranoid schizophrenia was a *"robust diagnosis"*;
- Mr S's symptoms had remained present *"while he had been taking an adequate dose of injected anti-psychotic medication, which was thought by those following him up to be keeping him well"*; and
- "*There is compelling evidence that immediately following his arrest Mr S had delusional beliefs involving his brother, whereas he either did not have these beliefs, or was concealing them, when reviewed on 21 December ... and on 10 and 24 December when he attended to have his medication administered. It is perhaps most likely that Mr S was concealing his abnormal beliefs and his experience of auditory hallucinations from those who were assessing him."* The consultant in forensic psychiatry noted that in the lead-up to his last notable relapse in 2002 Mr S had not been able to conceal his symptoms from others. He also noted that it was possible that an acute stressor had occurred after Mr S's assessment on 21 December 2009, and that his sister would not have been able to tell mental health services if there was anything of concern at the time he was assessed or afterwards.

The Independent Team has already noted that Mr S's sister was at a loss to know what had triggered Mr S's attack on his brother. This information underlines the final conclusion of the consultant in forensic psychiatry that, in the absence of any information supporting a sudden deterioration in Mr S's mental state, *"it is more likely that he had been concealing his ongoing symptoms from those around him".*

The Independent Team, on the basis of the pre-sentencing psychiatric report, therefore concurs with the Trust's investigation team that, on the basis of the information the mental health professionals had access to at the time they were conducting their assessments, there is nothing to suggest that any team member missed a critical piece of information that might have alerted them to the active delusions Mr S was experiencing.

Trust investigation team question 7: Was the induction of new staff adequate*?*
The Independent Team could not find any information in Mr S's chronology, or the Trust's own investigation report, to show why induction of new staff was given a specific focus in the report when essential components of Mr S's care and treatment had been unaddressed.

Trust investigation team question 8: What information was shared between the housing provider and Nottinghamshire Healthcare NHS Trust and was this adequate?
The Trust's investigation report does not demonstrate that sufficient attention was given to this question. The Trust's investigation team suggests in its report that the Company Secretary for the housing provider *"declined to attend interviews to speak with the panel",* but did provide *"brief answers to the general question of information sharing".* As already reported, the Independent Team has read the correspondence provided to Nottinghamshire Healthcare NHS Trust's investigation team. Its opinion is that the Trust's investigation team have not represented the housing provider fairly in its report. The letters from the housing provider set out clearly the constraints to its active participation in the Trust's investigation. Under the circumstances, the response from the housing provider was not unreasonable, and the Trust's investigation report should have reported on the information exchange between it and the housing provider more accurately than it did.

6.0 CONCLUSIONS OF THE INDEPENDENT TEAM

As a consequence of its

- analysis of Mr S's care and treatment;
- analysis of Nottinghamshire Healthcare's internal investigation report and interview records;
- meeting with the housing provider;
- meeting with Nottinghamshire Police;
- meeting with Nottinghamshire staff; and
- meeting with the sister of Mr S;

the Independent Team confirms its conclusion as stated at the beginning of section 5 of this report that the overall care and treatment of Mr S was of a good standard and that consultant [1] and the reallocation CPN are to be particularly commended on the efforts they made to make the transition of Mr S from a county-based community mental health team to a city-based one as smooth as possible for him.

Predictability
With regards to the predictability of the incidents that occurred, the Independent Team does not believe that the mental health services could have reasonably predicted that Mr S would act as he did. Mr S had attended reliably for his medication by injection between July 2006 and the end of December 2009. Although Mr S had been erratic in his attendance at outpatient appointments, bar 2007, he was seen at least annually and on these occasions he was also accompanied by his sister. Although asked about his voices and hallucinations, Mr S did not divulge to any professional that he continued to believe that he was bugged, or that he had a special mission to carry out. Mr S's sister did not raise any concerns with the mental health services about her brother over this same period. In fact, Mr S's sister had no information to provide as she was not at all aware that her brother continued to harbour these unusual beliefs.

Preventability
The only information that might have alerted mental health services to a possible deterioration in Mr S's mental state was held by Mr S's housing provider. The Independent Team considers that reasonable effort was made by the housing provider to determine whether or not Mr S was in receipt of mental health services in March 2009. The housing provider reported to the Independent Team being informed by the mental health service that Mr S was not in receipt of mental health services. The lapse of information transfer to the housing provider meant that Mr S's community mental health team was not aware at any stage of the concerns that prompted Mr S being discussed at a vulnerable person's panel in April 2009. Had the communication mental health team been aware, and in particular had they become aware about the graffiti considered attributable to Mr S, then they told the Independent Team that they are confident that they would have made assertive efforts to have assessed Mr S at home, and under the Mental Health Act if necessary.
However, even had this occurred with the resulting enhancement of Mr S's CPA status, all of the information provided to the Independent Team, including that

provided by Mr S's sister, suggests that it would not have been possible to have prevented the incident that occurred between the two brothers. Mr S's sister had been seeing Mr S daily in the antecedent period to the incident and she had detected nothing that she believes could have predicted the events that were to unfold.

Underlining this is the fact that when Mr S was assessed in custody, and under the Mental Health Act, by a consultant in forensic psychiatry, Mr S was determined to be fit for interview. The clinical records of this assessment report *"no evidence of psychosis during the interview"* and that there was nothing that led the assessing consultant to *"believe he* [*Mr S*] *was unwell".*

In addition to the immediate post-arrest assessment, the pre-sentencing psychiatric report in August 2010 concluded that in all probability Mr S had consciously withheld information about his symptoms from the clinicians who had come into contact with him. In such a circumstance, and with no conflicting information coming from Mr S's sister, it is unlikely that the mental health professionals would have been able to have prevented the incident that occurred.

7.0 RECOMMENDATIONS OF THE INDEPENDENT TEAM

The Independent Team's analysis of the care and treatment of Mr S and the subsequent evaluation of Nottinghamshire Healthcare NHS Trust's internal investigation report has resulted in five recommendations. These are:

Recommendation 1: Nottinghamshire Healthcare NHS Trust needs to ensure in its redesign of its electronic record that the facility to register a different correspondence address to the service user's own address is included.

In this case and currently there is complete reliance on individual staff to remember where an alternative correspondence address is required and this is neither satisfactory nor necessary.

The Independent Team suggests that the electronic record asks for confirmation of the correspondence address before allowing a professional to progress with the completion of the demographic information about a service user.

In addition to the above, the Independent Team suggests that Nottinghamshire Healthcare NHS Trust explores the feasibility of including a 'cc' prompt on all correspondence templates contained as integral components of the electronic system. The 'cc' prompt list could include the following:

- the service user;
- care co-ordinator;
- GP;
- family member/carer; and
- 'alternative correspondence address'.

Target Audience
Chair of the Clinical Records Group; the Chair of the Electronics Records Group/ Associate Medical Director Local Services the Clinical Information Systems Manager and the Project Manager for the Implementation of the electronic patient records project.

Timescales
The Independent Team does not consider it appropriate to determine timescales for the above recommendation. Nottinghamshire Healthcare NHS Trust has an electronic records development project currently underway and the above recommendation needs to be placed as a component of the development work already committed to. The Trust must advise the SHA and its commissioners regarding its plan in relation to this recommendation within three months of the acceptance of this report.

Recommendation 2: Nottinghamshire Healthcare NHS Trust needs to include in its routine demographic information collected on each service user details related to literacy. In this case, the first time the professionals appreciated that Mr S had literacy problems was during the independent investigation process. This situation is completely avoidable.

The Trust electronic records working group needs to be instructed to incorporate two 'forced field' questions about literacy in its demographic data. One question should be related to reading ability and one question relating to the service user's ability to write.

The Independent Team suggests that the expert advice of its speech and language therapists could be utilised in determining precisely what information is necessary so that the data is clinically useful to frontline staff.

Target Audience
Chair of the Clinical Records Group; the Chair of the Electronics Records Group/ Associate Medical Director Local Services the Clinical Information Systems Manager and the Project Manager for the Implementation of the electronic patient records project.

Timescales
The Independent Team does not consider it appropriate to determine timescales for the above recommendation. Nottinghamshire Healthcare NHS Trust has an electronic records development project currently underway and the above recommendation needs to be placed as a component of the development work already committed to. The Trust must advise the SHA and its commissioners regarding its plan in relation to this recommendation within three months of the acceptance of this report.

Recommendation 3: A suitably senior manager at Nottinghamshire Healthcare NHS Trust needs to engage with the lead for the Public Protection Unit at Nottinghamshire Police to explore how the Police National Computer facility can be appropriately utilised by mental health professionals where it is considered that it is in a service user's interest, or in the interests of public safety, for a mental health alert to be notated on the PNC for a named individual. Such an alert means that, if the named individual is stopped by the police under circumstances reflecting the mental health alert, then there is a greater likelihood that mental health services would be informed and would be in a position to determine the need for a mental health assessment.

In this case, there was no mental health marker on Mr S's mental health record. Although it cannot be said that, had there been such a marker, the incident that occurred could have been avoided, what can be said is that, had a marker been added to Mr S's PNC record, then there would have been a trigger for the police to have notified mental health services of concerns regarding Mr S in March and November 2009. This would have impacted on his mental health treatment package and resulted in enhanced monitoring of him.

Target Audience
Service Managers for City and County Adult Mental Health Services, Head of Integrated Governance and Performance, Clinical Leads for Adult Services and relevant senior managers in Older Persons' Services and Child and Adolescent Services.

Timescales
The Independent Team recommends that Nottinghamshire Healthcare NHS Trust provides the SHA and its commissioners with its projected timetable and action plan in relation to the above within three months of its acceptance of this report.

Recommendation 4
The assessment of the Trust's internal investigation has identified the need for Nottinghamshire Healthcare NHS Trust to further develop the standard of its serious untoward incident investigations.

In particular the presentation of the investigation reports written, so that the investigation report:

- Clearly sets out the terms of reference to which the investigation was delivered.
- Makes transparent the investigation methodology and the investigative tools and techniques used.
- Makes clear the aspects of the service user's care and treatment that meet or exceed local/national policy expectations.
- Makes clear the areas where significant lapses in care and treatment standards have occurred.
- Sets out the contributory factors to each identified significant care and/or treatment lapse and makes clear those contributory factors that are

considered by the investigation team to have had the greatest impact. (These could be termed ‘root causes’.)

- Delivers recommendations that address identified ‘root causes’ and are formulated so that they meet S.M.A.R.T. criteria.
- Makes clear the overall conclusions of the investigation team in relation to the terms of reference set and also in relation to the realistic potential for incident predictability and preventability.
- Where specific questions are agreed as requiring an answer in the investigation report, and these are set out alongside the terms of reference, the committee quality assuring the internal report must satisfy itself that these questions have been responded to and that the information presented is backed up by the information gathered during the investigation process.

The Independent Team suggests that the following will assist the Trust in consistently achieving the above:

- Appointing as the investigative lead a suitably senior individual (minimum band 8) who has received specific training in how to conduct an investigation and how to incorporate systems analysis (RCA) where required.
- Providing mentorship to those staff tasked with leading serious untoward incident investigations, notably homicides, absconding from a secure environment, in-patient suicides, and serious cases of assault to staff/visitors/other service users.
- Consideration of implementing a buddying system for a period of time while the Trust builds up its in-house investigation expertise.
- Using consultant-grade staff as clinical advisors to serious untoward incident investigations, rather than the lead professional in the investigation process.
- Having a clearly developed investigation report template with an accompanying style sheet and guidance notes, so that the author of the investigation report is guided through the process. The National Patient Safety Agency devised a number of resources to assist Trusts in evolving a report template that meets the national standard requirements, as well as the needs of local organisations.

Timescales

The Independent Team is aware that Nottinghamshire Healthcare NHS Trust has invested in the provision of investigation training for some of its staff. However, the reports seen by this Independent Team do not show the effectiveness of this. The Independent Team suggests that the Trust should present its proposal for achieving this recommendation to its commissioners within three months of the publication of this report.

Recommendation 5: There were omissions in the Trust's internal report (Mr S) that should have been identified and addressed via an effective quality assurance process.

The Trust must therefore devise a common set of criteria against which each Level 2 serious untoward incident investigation report is benchmarked. This set of criteria must be implemented across the relevant divisional committees who oversee and have responsibility for the acceptance of and quality assurance of serious untoward incident reports on behalf of Nottinghamshire Healthcare NHS Trust.

The Independent Team suggests that the following could be components of such a tool:

- Does the report have an Executive Summary that sets out:
  - The reason for the investigation;
  - The purpose of the report;
  - The main findings of the investigation team;
  - The conclusion of the investigation team;
  - The recommendations of the investigation team?
- Are the terms of reference plainly stated?
- Is the investigation methodology clearly described, including a list of the investigation tools and techniques utilised (this could be in an appendix)?
- Does the findings section of the report set out:
  - What aspects of care and treatment met with the required/expected standards?
  - The aspects of the care and treatment that significantly fell below the expected standards (if any)?
  - A systems analysis (i.e. root-cause analysis) for each individual aspect of care and treatment that fell significantly below the required standard. And are the most significant influencing factors stated plainly (i.e. root causes)?
  - Does the report comment on:
    - compliance with the care programme approach;
    - the quality and completeness of risk assessments, risk management plans and crisis intervention plans;
    - family/carer involvement by the responsible clinical team;
    - communication with partner agencies also engaged with the service user;
    - safeguarding issues where relevant?
  - If recommendations are made, do they target the 'most significant influencing factors' of the identified lapses in care and treatment?
  - Are the recommendations S.M.A.R.T.?
  - Are the conclusions of the investigation team clearly stated?

In assessing the above points the relevant committee must assure itself that the findings stated in the report are evidence based and that the language of the report is appropriate and objective.

Target Audience
The Medical Director and Head of Integrated Governance and Performance.

Timescales
Although seemingly straightforward, it may take the Trust's serious untoward incident committee some time to agree its final assessment tool for the benchmark of future investigation reports. Consequently, the Independent Team suggests that a prototype could be implemented within four weeks of the publication of this report, with the final model being agreed within six months of publication.

Recommendation 6: Nottinghamshire Healthcare NHST following its own internal investigation recommended that:

"Where possible, partner agencies should be engaged and agree to be involved in similar processes to ensure that the lessons learned can be shared to ensure ongoing improvements in the care of individuals whom they deliver services to."
This recommendation has not been delivered. Although the principle of the recommend was and remains appropriate, the way it has been formulated will make it challenging to deliver. Consequently the Independent Team recommends that:

- A senior Manager in each directorate is given the express responsibility for liaising with third party agencies to seek their cooperation with the internal review of serious adverse incidents where the third party has been involved with the service user, and their involvement is considered necessary.
- An executive director of the Trust is also identified as the lead executive for engaging with his/her counterpart in the involved partner agency. It is essential that the initiation to participate is initially made at this level in the organisation, especially following incidents of the magnitude of the Mr S case.
- The Trust develop a template letter that can be used by the Trust's internal investigation teams for the purpose of communicating with partner agencies following serious adverse incidents.

Target Audience
The Medical Director and Head of Integrated Governance and Performance.

Timescales
The Independent Team suggests that this recommendation is addressed alongside recommendations four and five.

Recommendation 7: The Housing Provider needs to reiterate to all relevant staff the importance of documenting significant communications about individual tenants with partner agencies such as mental health services.
With the increase emphasis on the independent review process following mental health homicide, domestic homicide, and the serious case review process for children and vulnerable adults it is important that housing officers understand that attention to detail in their written records is increasingly important.

When communicating with mental health services important information to record is: i) the reason for the communication; ii) what the context of the communication was; and iii) what the outcome of the communication was.

Target Audience: The Company Secretary for the housing provider concerned.

APPENDIX 1 BRIEF BIOGRAPHIES OF THE INDEPENDENT TEAM

Maria Dineen - Director of Consequence UK

Maria originally trained as a Midwife, and then developed her career in clinical risk management in 1994, developing one of the first clinical risk management and incident reporting systems in England for the Women's Centre at the John Radcliffe in Oxford. This was part of a research project in conjunction with Oxford University. From here she developed her knowledge and expertise in the field as an assessor for the Clinical Negligence Scheme for Trusts, and then as a Research Fellow at the Health Services Management Centre, Birmingham.

In 2000 she was invited to work with the Organisation with a Memory Team at the Department of Health in the early set-up phase of the National Patient Safety Agency. This work led to her being retained by the National Patient Safety Agency between 2001 and 2003 to work with its in-house team to develop and road test the now national model of incident investigation and root-cause analysis.

With regards to independent investigation work, Maria has extensive experience in leading independent investigations for Strategic Health Authorities in England and also the Health and Safety Executive in the Republic of Ireland. These investigations have largely been focused on homicide investigations, and Safeguarding – Adults investigations.

To date she has led over 35 independent investigations, of varying degrees of complexity.

In addition to the above, Maria published a book in 2002 on how to conduct an effective investigation that targeted health and social care. This book, *Six Steps to RCA*, is now in its 3rd edition and has sold over 7,000 copies to date.

Related, but separate to her investigation work, Maria has a long-standing interest in:

- facilitating workshops for staff wishing to improve their investigative skills; and
- supporting organisations and teams in developing meaningful critical success factors and facilitating a dynamic risk assessment regarding the team or organisation's ability to deliver these.

She has led an extensive range of workshops over the last nine years to Safeguarding Boards, professional safeguarding leads, NHS Trusts (all disciplines) and the Private Sector. Notably, she was engaged by the following organisations to deliver investigation training to their officers and to advise on how internal processes could be improved:

- The Nursing and Midwifery Council;
- The Royal College of Nursing;
- The Royal College of Midwives;
- The Mental Welfare Commission in Scotland; and
- King Faisal Specialist Hospital, Saudi Arabia.

Dr Anil Banymandhub – Independent Consultant Psychiatrist

Dr Banymandhub is a substantive Senior Consultant Psychiatrist and Head of Service for the Working Age Adult population in Calderdale. He has been employed by the South West Yorkshire Partnership NHS Foundation Trust since 1999 as a Consultant Psychiatrist.

He undertook his undergraduate medical training and his postgraduate Psychiatric specialisation at Leeds University and its affiliated hospitals.

Dr Banymandhub has been on the register of the General Medical Council since 1983 and he has been a member of the Royal College of Psychiatrists since 1989. He is recognised under the Mental Health Act as a Responsible Clinician and is Section 12 approved.

Dr Banymandhub carries out expert witness medico-legal work both nationally and internationally; he is also a member of the Mauritian Medical and Dental Council sub-committee for psychiatry and a special advisor to the Ministry of Health. In England he has worked extensively for the office of a previous Deputy Prime Minister, providing expertise in medico-legal matters for the Police and Fire Service in Scotland and Merseyside. Dr Banymandhub continues to provide medico-legal reports for the UK Armed Forces.

Justin O'Brien – Independent Nurse Advisor

Justin is currently the Head of Risk Management at South West London and St George's Mental Health Trust. In this role he is responsible for implementing the Trust's risk management strategy, providing advice and support to all services on clinical and general risk issues. His role includes the organisational commitment to effective complaints management and also the effective management and learning from adverse incidents.

Justin has been working in mental health services since 1983 and over the last 29 years he has acquired a wealth of experience.

Notable positions have been:

Deputy Chief Nurse, South West London and St George's Mental Health NHS Trust
April 2003 – April 2004
In this role Justin was responsible for implementing the Trust's Nursing strategy, providing expert nursing advice and supervision to lead nurses and senior managers.

Service Manager, South West London and St. George's Mental Health NHS Trust, 2001 – March 2003
This post held responsibility for adult mental health services within the Borough of Kingston.

Director of Clinical Services at The Priory Hospital, Roehampton, 1997 – 2001
Justin was responsible for all clinical services in a 112-bedded hospital with an establishment of 120 clinical staff. Services included general psychiatry, addiction treatments, and eating disorder services.

Lecturer in Mental Health, Kings College, London, August 2000
Justin was seconded, for two days per week, to work at Kings College, London, as a lecturer in Mental Health. The secondment was for 14 months.

Director of Therapeutic Community, 1995 – 1997
Justin managed a 28-bedded residential service for people with acute and enduring mental health problems, including personality disorders and severe self-harm cases, for this non-profit-making organisation.

Service Manager for Lambeth Healthcare NHS Trust, 1993 – 1995
Justin held general management responsibility for all mental health services at St Thomas' Hospital, including 2 admission in-patient units, emergency clinic, large outpatient services, psychology and psychotherapy departments, HIV services and a community mental health team based in North Waterloo. Staffing establishment in excess of 160.

Principal Care Manager with Bromley Care Services, 1990 – 1993
Justin was responsible for 10 nursing and residential care homes with a staffing establishment of 94 care staff.

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