Independent Investigation

into the Homicide of

Mr A by Mr B

Incident Date: 14 May 2007

Investigators:

Mr John Smith (Independent Nurse Consultant/Lead Investigator)

Ms Maggie Clifton (Investigations Manager)

Dr Colin Dale (Chief Executive)

Dr Michael Rosenberg (Independent Psychiatric Consultant)

Commissioned by:

South West Strategic Health Authority

Investigation Report Date:
October 2011

Incident Investigation Title:	Independent Investigation into the Homicide of Mr A by Mr B
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Authors and Job Titles	Mr John Smith (Independent Nurse Consultant/Lead Investigator); Ms Maggie Clifton (Investigations Manager); Dr Colin Dale (Chief Executive); Dr Michael Rosenberg (Independent Psychiatric Consultant)
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The independent investigation team wishes to thank all the staff at Avon and Wiltshire Mental Health Partnership NHS Trust who have willingly given their time to assist in providing an understanding of the care and management of the mental health service user Mr B. All staff who were interviewed were clearly open to sharing information and their own reflections regarding the homicide that occurred on 14 May 2007. Their contributions have assisted greatly in the production of this report. The Team particularly wish to thank Mrs Linda Hutchings, Head of Risk and Compliance, for arranging interviews and responding to our requests for information and documentation.

The independent investigation team extends their thanks to the co-operation and assistance provided by Mr B (service user) and Mrs A (wife of the deceased). Their openness and views have been extremely helpful in understanding and incorporating the service user and carer perspectives into this investigation and report.

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1 Executive Summary

1.1 Introduction

1.1.1 On 14 May 2007 Mr B (at the time an out-patient and community mental health service user of Avon and Wiltshire Mental Health Partnership NHS Trust) physically assaulted his stepfather and his mother in the family home. Mr A died at the scene of the assault as a result of the physical injuries received. Mr B was subsequently convicted of the manslaughter of his stepfather on the grounds of diminished responsibility. In January 2009 Mr B attended court and was placed on Section 37/41 of the Mental Health Act 1983. Currently Mr B remains an inpatient within a Mental Health Medium Secure Service

1.1.2 Following the incident the Trust established an internal serious untoward incident investigation team who produced a report on its findings in October 2007. The report generated a number of recommendations which were subsequently adopted by the Trust and incorporated into an integrated 'Homicide Action Plan' including recommendations from a further five internal investigations. Implementation of the action plan was performance managed by both the Trust and Strategic Health Authority.

1.1.3 This report sets out the findings of the independent investigation team. The Team reviewed the Trust's internal serious untoward incident report (October 2007) into the care and treatment of Mr B. In addition the independent investigation report was further informed by interviews with key stakeholders, a review of Mr B's health record (for which consent was provided), and a review of appropriate Trust documentation including relevant policies and procedures. Police records were also reviewed as part of the independent investigation process. Evidence-based/best practice (e.g. National Institute for Health and Clinical Excellence (NICE) Guidance) were also considered as appropriate to the treatment interventions.

1.2 Purpose

1.2.1 The independent investigation was commissioned by NHS South West. An independent investigation is required when a homicide has been committed by a person who is, or has been, under the care of specialist mental health services in the six months prior to the event. The purpose is to examine all the circumstances surrounding the care and treatment provided and in each case to identify any errors or shortfalls in the quality of the service and to make recommendations for improvement as necessary.

1.2.2 The independent investigation team was required to address Terms of Reference agreed by the NHS South West and key stakeholders, set out in full in Section 2 of this report.

1.3 Methodology

1.3.1 The independent investigation process was informed by:

- Interview with Mr B (perpetrator)

- Interview with Mrs A (perpetrator's mother and wife of the victim)
- Interviews with key staff:
    - Consultant Psychiatrist (Dr E)
    - Care Coordinator (Mrs D)
    - Community Mental Health Team Manager (Mr G)
    - Consultant Forensic Psychiatrist (Medium Secure Unit – Dr H)
    - Trust Head of Risk and Compliance
    - Trust Head of Psychology Services and Internal Investigation Team Member (Dr F)
- A review and analysis of Mr B's health record, including records from the specialist mental health trust, the General Practitioner, and a voluntary sector organisation supporting people with head injury and their carers
- A review and analysis of the police conviction and intelligence information for Mr B , Mr A (Mr B's stepfather) and Mrs A
- A review and analysis of the Trust's key policies and procedures in place at the time of the homicide (15 May 2007) and current (Full list at Appendix One)
- A review and analysis of the Trust's internal report and appendices dated 08 October 2007
- A review of the relevant NICE Guidance – evidence-based/best practice

1.3.2 The investigation team had sought to interview Mr B's previous Care Coordinator who had left the area and was unavailable. The investigation team also approached the voluntary organisation supporting people with head injuries to ask if a member of staff would be willing to attend an interview. However, the person who had worked with Mr B had left the organisation and no one currently employed there was able to add anything to the written records, which were provided. All records were accessed with the consent of Mr B.

1.4 Summary of main conclusions

1.4.1 The independent investigation team supports the findings and conclusions of the Trust's internal serious untoward incident report (October 2007), including notable practice (detailed in 1.7.16) and the following care and service delivery problems:

- A failure to follow the Trust's Vulnerable Adult Procedure
- A lack of Carer Assessment
- A failure to accurately record and investigate violent incidents
- A lack of a neuropsychological assessment
- A lack of accurate, updated risk assessment/risk chronology or risk management plan
- A lack of clear care planning goals with a change from enhanced to standard Integrated Care Programme Approach (ICPA)
- A lack of capacity within the Community Mental Health Team (CMHT)
- Inadequate staff knowledge base

1.4.2 The report also identifies root causes, with the key factors being:

- A lack of systematic risk assessment and risk management planning.
- A failure to collect risk information from relatives.
- A lack of a carer's assessment.
- The lack of specialist ongoing input into the management of Mr B's Obsessive Compulsive Disorder.
- A lack of a full exploration of the level of expressed emotion in the house, linking this to Mr B's previous violent behaviour.
- A lack of awareness among members of the team of the impact and implications of head injury upon Mr B's behaviour, and a lack of access to specialist neuropsychology advice.

1.4.3 The independent investigation team identified the following contributory factors:

- An overriding inadequacy by the CMHT to appreciate the complexity of Mr B's care and treatment needs. These failures were no doubt compounded by the fact that the CMHT did not take into account the evidence-based/best practice guidance outlined within NICE guidelines which was available at the time, in particular the guidelines on Obsessive Compulsive Disorder (NICE, 2005) and head injury (NICE, 2007). Local guidelines based on the NICE guidelines had not, however, been adopted by the Trust.
- There could have been much more comprehensive and rigorous assessment of both clinical risk and in incident and risk chronology record keeping
- The inadequate assessment of risk was attributable to a number of factors, including:
  - The failure to take account of the risk and event history which could be regarded as 'weak signals'
  - Mr B's reluctance to disclose the extent to which his OCD was impacting on his life
  - The conflict laden family dynamics, including domestic violence, which should have been recognised and taken into account
  - The failure of the CMHT to work collaboratively with Mr B's family and voluntary support organisation in managing Mr B's risks, treatment and care
- The CMHT should have considered Mr B's behaviour which was reported to be aggressive and intimidating by the voluntary day care organisation (October 2006)
- It is worthy of note that a significant undermining of the CMHT's ability to more accurately identify and appreciate the significance of the risks presented by Mr B was both his own and his mother's tendency to under-report the physical and mental health status of Mr B. In particular there was a tendency not to report those events and circumstances that may have given a greater level of cause for concern by the CMHT
- Whilst there are clear examples which should have prompted the CMHT to review Mr B's risk assessment and risk management plan, there is evidence to demonstrate that the accounts given by Mr B and his mother to CMHT practitioners could be regarded at times as being misleading

- The concept of a family-based approach in terms of working with and supporting the family does not appear to have been a consideration by the CMHT. Of note within the NICE OCD Guidelines and characterised within the accounts provided (post incident) by Mr B and Mrs A is the significant and potentially profoundly negative impact of OCD rituals and compulsions on the family unit. Mr B's OCD and resultant behaviours were clear setting conditions for stress, aggression and violence within the household. Unfortunately the CMHT remained largely unaware of these family dynamics
- Prior to the incident on 14 May 2007 the CMHT had assessed Mr B as being of low risk of harm to himself, and had not recognised the potential risk of significant harm to others. Mr B had been assessed by the CMHT as being able to manage his OCD symptoms adequately as a consequence of which the CMHT Manager and Care Coordinator were in the process of discharging him from the service. It is noteworthy that the Consultant Psychiatrist responsible for Mr B's treatment reported at interview to the independent investigation team that he was unaware of these plans and would have been concerned about such a decision
- The assessment of risk may have been more adequate if the CMHT had worked collaboratively to construct and maintain a clinical formulation, taking account of: information provided by a neuropsychological assessment; Mr B's pre-morbid personality characteristics; the historical evidence of impulsive/risky behaviours; the documented evidence of aggressive, intimidating behaviours; the extent to which Mr B's obsessive compulsive behaviours were impacting on his life and those of the family household; and the high levels of expressed emotion within the family dynamics
- In reality at the time of the incident (14 May 2007) the CMHT had failed to recognise the levels of risk presented. Consequently Mr B's significant ongoing treatment and care needs remained largely unrecognised
- Whilst the Trust's internal serious untoward incident investigation report identifies a number of system failures (described as care delivery problems and service delivery problems) it made no comment on the issue of professional accountability
- The recommendations arising from the Trust's internal serious untoward incident report have resulted in a significant number of service improvement responses for which the Trust should be commended
- The independent investigation team's report identifies a number of recommendations for consideration by the Trust. These include areas relating to service development, assurance and audit, staff training, clinical risk management and serious untoward incident investigation

1.5 Recommendations

1.5.1 Service Development

1 That a treatment and care pathway for service users with a diagnosis of Obsessive Compulsive Disorder (OCD) is established by the Trust in accordance with NICE Guidelines (CG31).

2 That the provision of Mental Health Teams' access to OCD specialist advice (in accordance with NICE CG31) is addressed by the Trust and commissioners.

3 That a treatment and care pathway for service users with a diagnosis of comorbid brain injury and mental disorder is developed by the Trust in accordance with NICE Guideline (CG56).

4 That the Trust's resource requirements to provide neuropsychological assessment services (including consultant assessment and case load management) are determined and considered as part of the Trust's business planning process.

5 That the issue of the Trust's mental health services having partnership working agreements with the Neurological Rehabilitation services be reviewed with commissioners as a service delivery priority.

6 That the Trust makes agreements with other agencies about how risk information will be shared with each other to ensure that critical information is not lost in the risk assessment and management process. This might include local authority, criminal justice, private or voluntary sector organisations.

7 Where a serious untoward investigation identifies system failures, timely assurance should be sought by the Trust (e.g. via clinical audit) to ensure such failures are not apparent within other teams.

8 The Trust should consider the potential clinical and organisational risks following any serious untoward incident investigation. Where appropriate:

- these risks should be 'weighted' (assessing the risk relative to other risks)
- the adequacy of controls (e.g. staff training, support and supervision levels) should be assessed
- treatment plans should be developed to reduce the risks.

9 The Trust should consider whether or not the risks identified in this serious untoward incident investigation are evident elsewhere in the organisation and assure themselves that there are no significant risks still outstanding which have not been addressed.

10 Where other agencies are working with or have a significant history of working with a service user who is involved in a serious untoward incident investigation, the internal investigation team should ensure their respective views are sought to inform the investigation process and subsequent organisational learning. This might include local authority, criminal justice, private or voluntary sector organisations.

11 To consider how the organisational learning from the Trust's serious untoward incident internal investigation report can be most effectively disseminated Trust-wide to key stakeholders who may not as yet have had the opportunity to access this information.

1.5.2 Audit

12 That the use of clinical formulations within CMHTs be included in the appropriate Strategic Business Unit's clinical audit programmes.

13 That the Trust's clinical supervision procedure with CMHTs be included within the appropriate Strategic Business Unit's clinical audit programmes, building on the audit carried out in the Adult Strategic Business Unit in 2009.

14 That implementation of the policy and procedures regarding 'Investigating Safeguarding Allegations' be included in the appropriate Strategic Business Unit's Clinical Audit Programmes.

1.5.3 Training

15 That the issue of appropriate grades of staff having access to the required level of training in 'Investigating Safeguarding Allegations' be reviewed to ensure that access opportunities and uptake for this training are adequate.

16 That the Trust reviews the training needs of Mental Health Teams with regard to awareness of and responsibilities as health professionals when domestic violence is alleged, suspected or observed.

17 That CMHTs' training needs regarding clinical risk management in accordance with evidence-based/best practice are evaluated. The provision of appropriate skills update training should be developed as required.

18 That the Trust ensures that health care professionals are not given responsibility for service users with Obsessive Compulsive Disorder unless and until they have received appropriate training in the condition, its care and treatment.

1.5.4 Policy and Procedures

19 That the Trust consider the need to develop Trust procedural guidance on the following (if this has not been done since the completion of this report):

- Suicide and serious self-harm
- Clinical risk management and the CMHT's responsibilities with regards to actual or suspected domestic violence
- Medication non-compliance

1.5.5 Internal Serious Untoward Incident report

20 That the issue of staff accountability be a reporting criterion clearly acknowledged within subsequent serious untoward incident investigations.

21 In accordance with the Trust's current procedural guidance, Terms of Reference for a Serious Untoward Incident investigation should be provided to the investigation team and clearly stated within future reports.

22 The National Patient Safety Agency (NPSA) Incident Decision Tree should be considered by an internal investigation team when determining possible system or individual failures within the organisation.

23 To provide Mrs A with the opportunity to receive the Trust's findings, recommendations and actions taken from the Mr B serious untoward incident internal investigation report.

1.6 Internal Investigation Report Recommendations

A number of recommendations were made by the internal investigation report. The independent investigation team were assured by the Trust's Head of Risk and Compliance that most of these recommendations had been implemented. These were recommendations regarding the care and discharge planning, carer's assessments and the involvement of families and carers to inform care and treatment decisions. This report does not replicate recommendations on those subjects, but focuses on recommendations which had not been implemented at the time of the interviews and on issues where there were no recommendations in the internal review.

2 Terms of Reference

2.1 Terms of Reference for Independent Investigation 2007/4538 set by NHS South West Strategic Health Authority in consultation with Avon and Wiltshire Partnership NHS Trust and Wiltshire Primary Care Trust.

The investigation is required to address:

- The care and treatment Mr B was receiving at the time of the incident (including that from non-NHS providers including the Specialist Voluntary Sector Day Unit);
- The suitability of that care and treatment in view of the Mr B's history and assessed health and social care needs;
- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies;
- The adequacy of the risk assessment and care plan and their use in practice, in particular regarding specialist OCD and neuropsychology service;
- The exercise of professional judgment and clinical decision making;
- The interface, communication, joint working and consistency between all those involved in providing care to meet Mr B's mental and physical health needs;
- The extent of services' engagement with carers and the impact of this;
- The adequacy and appropriateness of the internal investigation and Review.

Also to identify:

- Learning points for improving systems and services;
- Developments in services since the Mr B's engagement with mental health services and action taken since the incident;
- To consider if any omissions or issues identified in the investigation of the incident remain unresolved.

To make:-

- Realistic recommendations for action to address the learning points to improve systems and services that take into account service/provision change since the incident occurred;
- To report these findings and recommendations to the Board of South West Strategic Health Authority.

3 Introduction

3.1 Summary of the Incident

3.1.1 At the time of the incident Mr B was 46 yrs old, a divorcee living part of the time with his mother and step-father and partly in his own accommodation. From discussion with Mr B , his mother and clinicians it is apparent that Mr B spent a significant amount of time living at the home of his mother and stepfather.

3.1.2 It is noteworthy that Mr B was involved in two serious road traffic accidents, the first in 1988 in which he suffered extensive physical injuries including a fractured skull. Mr B was hospitalised for nine weeks, requiring a number of operations before being able to return to work. The documentation available indicates that Mr B made a good physical recovery.

3.1.3 Mr B self reports that it was following this road traffic accident that Obsessive Compulsive Disorder (OCD) first became apparent.

3.1.4 Mr B was first referred to mental health services by his GP in 1993. The reason for the referral at that time was for 'assessment and treatment for his OCD, his compulsive checking behaviour, excessive anxiety and threats of suicide'.

3.1.5 Mr B's consultant psychiatrist, Dr E, in his statement to the internal investigation reported that 'from time to time he (Mr B) had felt frustrated and this has resulted in lowering of his mood, stressful situations have made the symptoms worse'.

3.1.6 Mr B sustained a second road traffic accident in 2002, where again he sustained extensive injuries. The records indicate that Mr B suffered a severe brain haemorrhage and was in a coma for several weeks. In addition to the head injury Mr B suffered fractures to his ankle, skull and injury to one of his lungs. It is self-reported by Mr B (an account supported by his mother and his partner at the time) that he suffered a number of significant sequelae to this injury, including personality change, becoming increasingly intolerant of noise, increasingly irritable, with poor self esteem and low tolerance of frustration, including being much more prone to losing his temper than beforehand, and that his OCD also deteriorated noticeably.

3.1.7 Mr B had been continually involved with Mental Health Services from referral by GP in 1993 until the incident on 14 May 2007.

3.1.8 On 14 May 2007 Mr B returned from his morning exercise and accused his mother of moving some of his things. In the altercation that followed she told him to pack his bags and return to his own flat. Mr B pushed her down the stairs. Mr B then violently assaulted his stepfather, with his fists and feet, and his mother when she tried to protect Mr A. Police were called by a passer-by who heard Mrs A shouting for help.

3.1.9 Mr A was pronounced dead at the scene by paramedics. Police records report Mr B calmly eating his lunch when they arrived, and unconcerned about Mr A's welfare. 'Blunt force trauma

to head, neck and chest' were recorded as Mr A's cause of death. Mrs A suffered a fractured jaw and bruising to her face, body and limbs.

3.1.10 In May 2008 Mr B was convicted of manslaughter on the grounds of diminished responsibility. He was made subject to an Interim Hospital Order (Section 38) of the Mental Health Act 1983. In January 2009 Mr B attended Court and was placed on Section 37/41 of the Mental Health Act 1983.

3.2 Background and context

3.2.1 Mr B had received support and treatment from specialist mental health services over a period of 14 years. He had accessed in-patient, out-patient and community mental health services. The reason for referral and subsequent interventions was for assessment and treatment for OCD, including compulsive checking behaviour, excessive anxiety and threats of suicide. At the time of the incident Mr B was an out-patient of the mental health service, his treatment and care were underpinned by the Care Programme Approach (CPA). Interventions included medication, prescribed and monitored by his consultant psychiatrist and monthly meetings with his care coordinator. In March 2007 Mr B attended an out-patient appointment with his consultant psychiatrist. Mr B's mother also accompanied him to this appointment when both reported that his mental state was much improved and his stability was maintained. Mr B's consultant psychiatrist, at interview with the independent investigation team, confirmed that there were no concerns reported regarding Mr B's mental health state at that time. It is also reported that Mr B was compliant with medication prescribed. The last contact with the mental health service (prior to the homicide) was in April 2007, when he was visited by his Care Coordinator at home. At that meeting Mr B reported that he "hated people moving his things" but that he was generally managing to cope with his OCD. The Care Coordinator at the time did not explore what Mr B meant by this statement. At interview the Care Coordinator made the point that she had only recently met Mr B. It is worthy of note that at interview Mr B's Care Coordinator commented on her recent secondment to the 'Working Age Adults' mental health services from 'Older Adult' mental health services. She commented also on her relative inexperience of working with the working age adult client group.

3.3 Methodology

3.3.1 Consent was sought from and given by Mr B to access relevant health, police and court records prior to these being seen by any member of the independent investigation team. The Independent Investigation process was informed by:

- Interview with Mr B (assailant)
- Interview with Mrs A (Mr B's mother and wife of the victim)
- Interviews with key staff (interviews were audio-recorded and transcripts sent to interviewees for confirmation of accuracy/amendment):
    - Consultant Psychiatrist (Dr E)
    - Care Coordinator (Mrs D)

  - Community Mental Health Team Manager (Mr G)
  - Consultant Forensic Psychiatrist (Medium Secure Unit – Dr H)
  - Trust Head of Risk and Compliance
  - Trust Head of Psychology Services and Internal Investigation Team Member (Dr F).
- A review and analysis of Mr B's health record including records from the specialist mental health trust, the General Practitioner, voluntary sector organisation supporting people with brain injury and their carers
- A review and analysis of the police conviction and intelligence information for Mr B , Mr A (Mr B's stepfather) and Mrs A
- A review and analysis of the Trust's key policies and procedures in place at the time of the homicide (15 May 2007) and current. (Full list at Appendix One)
- A review and analysis of the Trust's internal report and appendices dated 08 October 2007
- A review of the relevant NICE Guidance – evidence-based/best practice – NICE (2005); NICE 2007).
- The independent investigation team were unable to interview a previous care coordinator who had left the Trust. The investigation team also approached the voluntary organisation supporting with people with head injuries to ask if a member of staff would be willing to attend an interview. However, the person who had worked with Mr B had left the organisation and no one currently employed there was able to add anything to the written records, which they provided.

3.3.2 The team completed:

- A timeline of Mr B's involvement with services up until the incident date (14 May 2007).

3.3.3 The team undertook:

- A review of Mr B's treatment and care provided by AWP
- A review of the contributory factors and Root Cause Analysis.

3.3.4 From the findings and analysis of the investigation, the team made recommendations for consideration by AWP and NHS South West to further support organisational learning from the homicide.

3.3.5 The independent investigation team are required to present their report findings to NHS South West for consideration and implementation.

3.3.6 The investigation team was led by Mr John Smith, supported by Ms Maggie Clifton, Dr Michael Rosenberg, and Dr Colin Dale.

3.3.7 This Level 3 (independent) investigation was commissioned by NHS South West from Caring Solutions UK Ltd. The investigation commenced in March 2010 and is scheduled for completion in November 2010.

4 FINDINGS

4.1 Chronology of events

It is of value to review Mr B's service provision of care and treatment in the preceding 15 months period, given the number of notable changes in service provision took place during this period.

Chronology of events	
Date	**Event**
28 February 2006	In an entry within the voluntary support organisation records, a note made by staff recording the details of a telephone conversation with a 'mental health worker' describes Mr B's behaviour as 'increasingly awkward/difficult for us to handle due to his OCD and manipulation, his impact on the group is now negative due to verbal aggression/brittle nature'.
9 March 2006	A 'professionals' meeting' at the day service discussed concerns expressed by the service about the continued appropriateness of Mr B attending this service. At this meeting Mr B is reported to have alleged that his mother, Mrs A, was being abused physically by her husband. Mr B's Care Coordinator at the time, Mrs C, agreed to discuss this with Mrs A.
23 March 2006	At Mr B's Care Programme Approach (CPA) meeting, the day service provided a one-month notice period before he would be discharged from this service. Within the records two reasons are given for Mr B's discharge from this service: i) that Mr B had made excellent progress, ii) that the day service service staff were not trained to deal with aggressive behaviour and Mr B's behaviour was having an intimidating impact on the other service users. Mrs A had at the time also reported that she had concerns about the impact on her of being Mr B's main carer. A proposal was made for Mr B to attend a local mental health charity to link with activities at the day centre. A referral was subsequently made for Mr B to access befriending support, however a suitable befriender could not to be identified.
05 April 2006	Mrs A disclosed that she was being subject to physical abuse by her husband.
28 April 2006	Mr B's placement at the specialist day service ceased. Prior to this he had attended the day service two days per week. It is noteworthy that Mr B himself reports that this facility provided him with the 'opportunity to regain his confidence and self esteem', following his road traffic accidents. Whilst a one-month notice period had been given by this day service no substitute activity had replaced this void despite

	several attempts.
22 September 2006	Mr B was discharged from the employment service project, because the work that Mr B had aspired to attain had not become available. It is of note that Mr B himself reports to the independent investigation team at interview that he had very clear and specific aspirations about occupation (i.e. a charitable goods collector). Mr B was clear about only pursuing this specific type of work and clearly resistant to considering other options. The employment service had proposed a co-worker could possibly be made available in the future, should such work become available.
30 June 2006	Mrs A left a telephone message for the CMHT Care Coordinator Mrs C, reporting that a fight had taken place between Mr A and Mr B. This incident resulted in police attending.
26 July 2006	Mrs A filed for divorce. Mr A was cautioned by police regarding domestic violence and bound over until 2009. Mr B provided evidence to the police regarding Mr A's physical abuse towards his mother.
27 July 2006	Mr B reported to Mrs C that his OCD was worse when he was stressed. Mr B rejected a one-off 1 hour support worker assistance to help him moving back to his own home. He requested a lift to the supermarket as an alternative use of the allocated time.
29 September 2006	Mrs C left the service. Mr B reported to the independent investigation team that she had provided him with significant support. A replacement care coordinator was unavailable until 12 November 2006.
12 November 2006	Mrs D was appointed as Mr B's Care Coordinator. Mrs D reported at interview that she had previously worked within an 'Older Adults Team' and had requested that she, as part of her career development, take on a secondment within the 'Working Age Adults' service. Mrs D reported that there was no handover of the case and that her understanding was that she had been given the brief by her line manager of the CMHT to work towards discharge of Mr B from the service. This understanding was confirmed by Mrs D's line manager Mr G.
22 January 2007	Mr B failed to attend his out-patient appointment with Dr E (a follow-up appointment was sent).
14 February 2007	Mr B attended the out-patient clinic early to cancel his appointment. A phone call follow up by Care Coordinator Mrs D to Mrs A was made – no concerns were reported.
08 March 2007	Mrs D, Care Coordinator, made a home visit. Mr B reported that he was keeping

	himself busy by cycling and going to the gym. The Care Coordinator Mrs D reduced his CPA level from Enhanced to Standard. It is noteworthy that Mr B's consultant, Dr E, at interview reported to the independent investigation team that no one had discussed this change in CPA level with him or the proposed discharge planning of Mr B from the service. Dr E reported that he 'would have been uncomfortable' with this decision.
8 March 2007	Following the home visit, Mr B's ICPA Care Plan review took place. Mr B reported that he had worked out a way of coping with his OCD, with his fitness programme and increased social contact. He did not feel the need for any more activities. Mr B spent some days at his mother's home. Mrs A, his main carer, felt that he had made progress and was more settled. Staff also felt he had made progress and that the activities were keeping him well. The plan was to continue medication reviews with this consultant and to continue monthly meetings with the care coordinator. The risk screening section was left blank. The date for the next ICPA meeting was set for 08 March 2008
19 March 2007	Mr B and his mother attended Dr E's outpatient clinic (re-arranged after the cancelled appointment on 14 February 2007). Mr B self reported that he was feeling better than he had done so for a long time. Mr B reported that he was taking his prescribed medication (Fluoxetine 20 mgs) on alternate days.
11 April 2007	A home visit was undertaken by Mrs D, care coordinator. Mr B reports that he was continuing with his exercise routine and had gained some weight. Of note, Mr B stated that he hated people moving his things, but was generally managing to cope with his OCD. The Care Coordinator Mrs D reported that Mr B was reluctant to explain further what he meant, and that given that she had known Mr B for only a short time it did not seem appropriate to explore further.
14 May 2007	Date of homicide, (see paras 3.1.8 – 3.1.12 for details)

4.2 Care and Service Delivery: Issues for consideration

4.2.1 The Trust's internal investigation report identifies six care delivery problems and 2 service delivery problems. In addition to these problems, the independent investigation team has identified a number of further care and service delivery problems. Care and service delivery problems are reported in Sections 4.2.3 and 4.2.4 respectively.

4.2.2 A number of issues give cause for concern regarding Mr B's treatment and care. These have been classified as either Care Delivery or Service Delivery Problems, in line with the NPSA Root Cause Analysis methodology. On occasions this has seemed slightly arbitrary as some issues could be included under either heading. In these cases the most logical of the two has been chosen. Some issues have also been identified as both delivery problems and contributory factors – in these cases, the issues are reported in detail in this Section, with a brief description and cross-references in Section 4.3 on Contributory Factors. Although sometimes repetitive, it is

nonetheless more important to focus on the relevant organisational learning from the factors identified rather than a preoccupation with the classification.

4.2.3 Care Delivery Problems

4.2.3.1 Within the discharge planning provisions, including gradual withdrawal of support, there is a note that Mr B would develop greater independence by gradually increasing the amount of time he spent in his own home. However progression appeared to be extremely slow. The CMHT Manager, Mr G reports that Mr B was using his own home infrequently to the extent that it seemed an inappropriate use of housing benefit entitlement. It is noteworthy that no 'activities of daily living' skills assessment of Mr B was undertaken as part of the management of the plan or the potential impact of Mr B's OCD on completing basic cooking or cleaning tasks. Dr E reports the team did not have the input of an Occupational Therapist who would have undertaken such as task. It is noteworthy that Mr B at police interview describes a morning ritual of rising at about 3.00 am and spending around 45 minutes in the lavatory then cleaning his teeth, taking a wash, then taking his clothes and equipment downstairs and arranging it in a specific way, then having breakfast between 04.15 and 04.30 before going to the gym at 08.00. According to Mr B's statement he followed the same ritual on the day of the offence. Mr B self-reports that he would then return to his mother's home and prepare his own mid-day meal. Mr B also reports he would later attend the local gym and cycling shop where he would meet 'friends'. Within the clinical history documentation (and confirmed by Mrs A) it was not unusual for Mr B be retiring to be as early as 5 – 6 pm. The interdependency of Mr B with his mother Mrs A may not have been fully taken into account.

4.2.3.2 No relapse prevention plan appears to have been identified other than the monthly Care Coordinator visits (the next scheduled meeting was planned to be at Mr B's own home).

4.2.3.3 The Consultant Psychiatrist informed the independent investigation team that he was unaware of a number of incidents in which Mr B had threatened to harm others or himself, e.g. Mr B during an argument with his partner he grabbed the steering wheel whilst his partner was driving and the vehicle was driven into a ditch (14 June 2003) and an undated letter from Mrs A to the CMHT (2003) in which she alleges her son 'pulling a knife on myself and my grandchildren'. (At interview with the independent investigation team Mrs A acknowledged the incident but minimized its impact.)

4.2.3.4 With reference to supporting Mr B to move his belongings to his own home, there appears to have been only one hour made available to him as a 'one-off' by the CMHT. Mr B stated that given his OCD he would need significantly more time than that allocated and consequently declined this support, opting for a lift to the local supermarket as an alternative use of the allocated time.

4.2.3.5 The ICPA meeting held on the 23 March 2006 appears not to take into account the concerns expressed by the day service about managing Mr B's difficult, intimidating aggressive, behaviour displayed towards others. There appears to have been no consideration as to the antecedents or

consequences of this behavioural disposition, whether the behaviour was situation specific or the potential implication for this behaviour to occur or be occurring in other settings – e.g. in the home. There appears to have been no review of Mr B's risk assessment as a consequence of these behaviours being reported.

4.2.3.6 The telephone message from Mrs A to the Care Coordinator Mrs C 30 June 2006 (recorded on file) in which she reports fighting between Mr B and Mr A appears not to have prompted further investigation or a review of Mr B's risk profile. Clinicians interviewed as part of the Independent Investigation acknowledge that the CMHT clearly underestimated Mr B's risks and indeed did not recognise him as a risk to others despite a significant history of threats and actual aggressive behaviour towards others.

4.2.3.7 Mr B's ICPA Care Plan review documentation (08 March 2007) documents positive accounts of stability and indicative progress made by Mr B. However, if one reviews Mr B's events time line for the previous 12-18 months prior to the incident on 14 May 2007 a number of significant events occurred which should have been considered in terms of potential impact on Mr B's mental health stability, particularly given the fact that Mr B's response to environmental stressors was a known precursor to exacerbating his OCD symptoms.

4.2.3.8 Mr B reported at interview with the independent investigation team that he would also leave his mother's home to avoid contact or conflict with Mr A, who he states would repeatedly goad him about his mental health, calling him a 'freak' and 'mental case'. Neither Mrs A nor Mr B reported Mr A's behaviour in this regard until after the homicide, so that that the CMHT supporting Mr B were unaware of these significant family tensions and conflicts.

4.2.3.9 Mr B also reported to the independent investigation team that he had heard his mother being abused by her husband. When asked what he did about this he replied 'nothing, as it was not his place to do so'. It is of note that this information appears not to have been disclosed to the CMHT previously.

4.2.3.10 With reference to Mr B's assessed health and social care needs, there appears to have been no assessment or account taken of:

- How Mr B spent a typical day or week
- The extent of any social engagement
- The ongoing harassment from his stepfather
- The level of intrusion encountered by Mr B in managing his OCD
- The level of high expressed emotion (tension) within the household living with his mother and step-father
- The level of anxiety and stress being encountered by Mr B in response to the belief that either his mother or stepfather were entering his bedroom and moving his property. It is noteworthy that at interview Mrs A reported to the independent investigation team that

her husband would deliberately go into Mr B's room when her son was out and move his property because it would cause her son to become anxious and upset.

4.2.3.11 It is noteworthy that Mrs A herself was a Vulnerable Adult. Mrs A was supported by Care Coordinator Mrs C to attend an assessment by the Carers' Support group (5 April 2006) at which she disclosed the abuse she had suffered from her husband Mr A. An incomplete Trust Carer's Assessment remains on file. At interview with the independent investigation team the Care Coordinator Mrs D reports that on reflection she could have completed the assessment but also queried why the Carer's Association were not lobbying on behalf of Mrs A. Mrs D commented that this in part might have been attributable to Mrs A's own possible disengagement.

4.2.3.12 The decision to reduce Mr B's ICPA status and the intention to move to discharge was not discussed with his Consultant Psychiatrist who reported at interview that he would have been uncomfortable with such a decision. There was clearly a lack of communication, clarity and agreement between the multi-disciplinary team in formulating and delivering a co-ordinated care and treatment plan.

4.2.3.13 The CMHT did not recognise the need for accessing specialist advice regarding his OCD. Subsequently specialist advice was not sought to advise or inform Mr B's care plan with regard to his OCD diagnosis. This may in part have been attributable to the incumbent care coordinator's lack of knowledge. However, other, more experienced practitioners were involved over time with Mr B and did not recognise the implications of the NICE guidelines requirements.

4.2.3.14 When Mrs D (Mr B's care coordinator) was asked by the independent investigation team if she was aware of the NICE guidelines regarding OCD she was unable to demonstrate a working knowledge of this information.

4.2.3.15 A clear inadequacy of Mr B's assessment of care needs appears to have been the failure to assess and understand the impact of his rituals and compulsions on others and the extent to which family and carers were involved in supporting or carrying out behaviours related to the disorder.

4.2.3.16 The CMHT should have considered the comorbid conditions e.g. Mr B's brain trauma, predisposing personality characteristics and psychosocial factors (e.g. Mr B's home circumstances, family conflicts, levels of stress) that would potentially increase the risk of violence and aggression.

4.2.3.17 With reference to Safeguarding Vulnerable Adults, the Trust did have a 'policy and practice in place for the protection of vulnerable adults from abuse in Swindon and Wiltshire'. This document was first issued in 2001 and has been subject to subsequent update revisions. The version provided to the independent investigation team and in place at the time of the

incident was in excess of one hundred pages. The document does provide guidance for the staff on the actions to take should a vulnerable adult situation be suspected.

4.2.3.18 There were a number of instances in which the 'Safeguarding' procedure appears not to have been implemented by the CMHT. There is a lack of clarity as to why the Vulnerable Adults procedure was not followed through in 2005, when the police found Mr B walking barefoot on the motorway. He was subsequently taken to hospital via Section 136 of the Mental Health Act 1983.

4.2.3.19 The CMHT were aware of Mrs A's disclosure of physical abuse by her husband. Had the vulnerable adults procedure been followed at this juncture, there would have been a greater likelihood of the police knowledge/intelligence regarding Mr A's history of violent offending would have been shared with the CMHT. It would also have ensured the consideration that Mr B himself was also a potentially vulnerable adult.

4.2.3.20 The failure to follow the Vulnerable Adult procedure resulted in a lost opportunity for a full multi-agency review of the risks presented.

4.2.3.21 The Trust's Integrated Care Programme Approach (ICPA) and the Assessment and Management of Risk Policy (March 2007) advocates that 'there are effective arrangements to record and communicate ICPA and risk arrangements that are accessible for service for each service users at all times'. In addition the policy states that 'ICPA plans (including risk) are reviewed with all members of the partnership on at least a yearly basis or more often as required to maintain a safe and effective partnership'. The ICPA policy identifies the following responsibilities:

- Team Managers: 'All team managers are responsible for the implementation, audit and review of the ICPA in their team …. They must manage the performance of all care co-ordinators in the team'.
- Care Co-ordinators: '.. Have the key responsibility and accountability with the ICPA for the effective assessment, care pathway planning, implementation, delivery, co-ordination, recording, communication and review of the needs and the care and treatment of their allocated service users, their support structure and carers, and the effective management of risk'.

4.2.3.22 From a review of the available documentation and interviews with key stakeholders it is apparent that these operational policy requirements were at times less than adequately discharged, examples of which include:

- The failure to recognise Mr B's risk towards others
- CMHT members stating they were unaware of some Mr B's documented risks, including instances of threats of and actual harm to others
- Failure to maintain, update and review Mr B's risk chronology. The report of aggressive and intimidating behaviour displayed by Mr B toward others whilst attending the day service

was known to the CMHT but this information did not inform the risk assessment or risk plan. Nor did it appear to prompt further inquiry into Mr B's behaviours within the home

- There appeared to be no attempt at functional analysis of these behaviours or to utilise the accounts of intimidating, aggressive or violent behaviours displayed by Mr B to inform or refine a clinical formulation
- A telephone message left by Mrs A for the CMHT Care Coordinator, Mrs C, in which she reported a fight between Mr B and his step-father (30 June 2006) was recorded within the health care record but does not appear to have received any follow up investigation or have been recorded within the risk chronology.

4.2.3.23 The Trust's 'Health and Social Care Records Management Policy for Paper Records' (version issue 10 October 2006) was the policy in place at the time of the incident and was (along with subsequent revisions of the document) reviewed by the independent investigation team. The following extracts are of note:

- Sect. 4.1 'The line manager is accountable for ensuring that compliance with this policy is assured through appropriate managerial arrangements, including training, performance management and the use of disciplinary procedures where necessary
- Sect. 5.7 'The Trusts mandated systems for record keeping are the MHIS for electronic records and the single health and social care record file for paper records. No other records keeping systems or formats are approved for use. This means that no independent data work groups or separate paper filing systems may be used for the purposed of filing or storing Health and Social Care records'
- Sect 10. Staff training. 'It is the responsibility of the line managers to identify and arrange for suitable on the job training to be provided and ongoing training identified through the KSF and appraisal process'
- Sect. 11. Monitoring and Audit. 'Record clinical quality audits will be conducted in accordance with the Schedule of Audits managed by the Clinical Audit Committee'.

4.2.3.24 It was confirmed by staff interviewed by the independent investigation team that:

- A single health care record was not maintained. Instances would therefore occur on occasions whereby staff recording notes in one file would be unaware of events recorded in another set of notes
- One interviewee reported that members of the team would have their own systems to store information
- One interviewee reported that the weekly multi-disciplinary meeting, at which team members raised patients for discussion, was minuted (on occasions) by a secretary, but was unsure where these notes went after the meeting. It was acknowledged that these discussions would not always be recorded within the respective patient's health record
- It was reported that since 2007 the MHIS electronic record has enabled some core patient information to be stored on one file, however a paper health record also

continues to be used. It is noted that the Trust is currently embarking on the implementation of a single electronic patient record system (RIO)

- Reviewing the diary entries within Mr B's health care record it was noteworthy that some sheets did not have the name of the patient in the 'header' nor were continuation sheet numbers in use
- There is documentary evidence within the health record that some attempt had been undertaken to develop an incident/risk chronology, however no entries appear to have been documented after 2005. The documentation entries are extremely brief and overall inadequate in terms of content and providing the information required by the reporting template. This information appears not to have informed any subsequent treatment and care planning for Mr B. There are incidents reported within the health record that have not been entered on the risk chronology
- There is no evidence of the incident/risk chronology being updated or reviewed by the multi-disciplinary team
- The ICPA Care Plan in place the time of the incident (15 May 2007) was undertaken on 08 March 2007. Mr B and his mother are recorded as being present at the meeting, but the care plan was not signed or dated by Mr B or his Care Coordinator. The plan does not make reference to the proposed discharge from the CMHT. The on-file copy of the ICPA Care Plan has a number of reporting elements which are incomplete, including:
    - Legal status/MHA status
    - Changes in service user needs/circumstances
    - Have the carer's needs changed? (Y/N)
    - Should these needs be reassessed? (Y/N)
    - New Risk Screen completed? (Y/N)
    - Formal risk assessment completed? (Y/N)
    - Advanced statement completed? (Y/N)
    - Unmet needs and actions taken
    - Service user comments including issues or disagreements
    - Carer comments including any issues or disagreements
    - The copy of the ICPA Care Plan Review on file was unsigned and undated.

4.2.3.25 The Section 'Additional things we have agreed to work on what we want to achieve and how' had only two statements, i.e.

- Medication reviews with his Consultant Psychiatrist
- Monthly meetings with his Care Coordinator to continue.

4.2.3.26 It is of note that there is no evidence of any recovery focused care plans or any relapse prevention strategies identified with the care plan. No occupational activity or work planning focus is evident with the Care Plan review. A review of the Care Plan was scheduled for 08 March 2008.

4.2.3.27 Given Mr B had suffered two serious road traffic accidents (1988 and 2002) and as a consequence is reported to have suffered severe brain injuries there is no evidence within the

health record that NICE Clinical Guidance CG56 (2007) on *Triage Assessment, Investigation and Early Management of Head Injury in Infants, Children and Adults* had been considered as part of the treatment and care planning process. It should be noted that there were no local guidelines based on the NICE document.

4.2.3.28 The NICE CG56 advises that a neuropsychological assessment should always be obtained to inform the mental health care plan. The Guidance also advocates a joint CPA approach should be adopted between mental health services, neurological rehabilitation services and other agencies. It is noteworthy that the Guidance advocates that the most appropriate care co-ordinator from the agencies involved should be identified through a joint CPA process. It is noteworthy that the appointed Care Coordinator did not have under-pinning knowledge of brain injury or OCD. The above recommendations in Mr B's case were not followed. It appears that there was no acknowledgement of this Guidance within Mr B's treatment and care planning, although, again, there were no local guidelines based on this NICE document.

4.2.3.29 The Consultant Psychiatrist when asked by the independent investigation team about the appropriateness of referring Mr B for a neuropsychological assessment stated that had he been of the view that one would have been of benefit he would have referred Mr B to an appropriate service, possibly via his GP. The Consultant Psychiatrist pointed out that over a period of time Mr B had been seen by a number of psychiatrists, psychologists, nurses and social workers, none of whom had thought fit to refer Mr B for neuropsychological assessment.

4.2.3.30 It would nonetheless have seemed prudent (given Mr B's clinical presentation and brain injury history) for a neuropsychologist to assess the extent of Mr B's functional difficulties, which may be attributable or otherwise to the brain injuries arising from his road traffic accidents. Such an assessment would have assisted any clinical formulation or given rise to the consideration of differential diagnoses such as Organic Personality Disorder. Implementation of any recommendations from such an assessment would however have depended on the availability of staff to deliver and on Mr B's motivation to engage in therapy.

4.2.3.31 The psychological interventions undertaken with Mr B (Cognitive Behavioural Therapy (CBT) may have been enhanced with the additional support provided via a community support worker. Additional support of this nature might have led to improved engagement with and compliance with the programmes. Any benefit from this approach would have depended on Mr B's willingness to engage for long enough to bring about change which had not been evident in the attempts that were made to improve his symptoms through CBT. It may be that the CMHT may well have thought that the voluntary sector specialist day service had more skills and access to their own specialist advice in this area.

4.2.3.32 The NICE Guidance (2005) *Core interventions in the treatment of OCD and BDD* acknowledges the need for health professionals to consider the impact of the patient's compulsions on members of the family. With reference to Mr B's compulsions these appear to have had a major impact on both his mother Mrs A and his stepfather Mr A. It is noteworthy that Mr B

self-reported that his stepfather continually ridiculed him regarding his OCD and associated rituals. The perspectives of Mrs A and Mr A if sought may have provided a more comprehensive and informed assessment. There is no evidence to indicate that these two individuals' perspectives were sought to inform the risk assessment.

4.2.3.33 The risk assessments on the health record assess Mr B's risk of harm to himself as low. All the clinicians interviewed reported that they had not considered Mr B as a risk to others.

4.2.3.34 A home circumstances report was not undertaken, nor was a family history apparent in the health record.

4.2.3.35 The CMHT could have attempted to assess the impact of Mr B's rituals and compulsions on both his mother and his stepfather. There was also an apparent lack of recognition of the impact of both Mrs A and Mr A's behaviours in terms of impacting negatively on Mr B's compulsions and rituals.

4.2.3.36 There appears from a review of the health record to be a number of risk factors in terms of aggressive/violent behaviours that were not fully acknowledged by the multi-disciplinary team including:

- Mr B's predisposing personality characteristics
- Psychosocial risk factors – e.g. family conflict
- Conflict between Mrs A and Mr A(history of domestic violence)
- Conflict between Mr A and Mr B (Mr A reported to goad Mr B regarding his behaviours)
- Conflict between Mrs A and Mr B at times (Mrs A being described by her son as 'controlling and going off on one')
- Stress as a self-reported trigger to exacerbate Mr B's compulsions – 'making his OCD worse'
- Mr B's deficits in terms of emotional regulation and impulse control (a history of temper outbursts, threats of harm to self and others, history of aggression towards others).

4.2.3.37 Exploration by health professionals with Mr B of the hidden distress and disability commonly associated with his diagnosed condition does not appear to have been pursued.

4.2.3.38 It appears that there had been a plan to increase the dose of Fluoxetine but this met with problems - Mr B reported side effects from this and most of the medications prescribed over the years and in addition his compliance was poor. Some of the reported side effects may have been more due to his reluctance to take medication. As well as the use of high dose Fluoxetine 60mgs (instead of the 20 mgs he tried and then stopped taking) or Clomipramine (at least 150mgs if not more instead of the 75mgs he seems to have taken if at all) it may well have been appropriate to pursue the cautious introduction of a neuroleptic which at some point was attempted (Olanzapine). However, this may have proven problematic because of the brain injury and Mr B could have been at risk of seizures induced by the medication.

4.2.3.39 Although the internal investigation team suggested that access to family therapy might have been of value, the independent investigation team concluded that traditional family therapy would probably not have been appropriate, but did conclude that more attention might have been given to supporting Mrs A and educating her about the negative impact that her apparent collusion might be having. Some attempt to engage Mr A might have been attempted, although it seems very unlikely that he would have complied with family support.

4.2.3.40 It would have been more useful to support Mr B in his own accommodation with a support package that made it less likely that he need to gravitate back to his mother's home. A full social circumstances assessment might have led to such support being provided.

4.2.3.41 According to NICE Clinical Guideline 31, (2005) para 1.6.1.3, a small minority of adults with long-standing and disabling obsessive-compulsive symptoms that interfere with daily living and have prevented them from developing a normal level of autonomy may, in addition to treatment, need suitable accommodation in a supportive environment that will enable them to develop life skills for independent living. In the absence of detailed understanding of the tensions in the home, this does not appear to have been considered as an option for Mr B by the CMHT.

4.2.3.42 There was no evidence of a clinical formulation having been undertaken. The undertaking of a clinical formulation could have provided an opportunity for the multi-disciplinary team to fill the information gap between diagnosis and treatment. It may well have provided a foundation for a better-informed rationale for the care and treatment planning for Mr B. A clinical formulation might have increased the opportunity for considering any differential diagnosis, e.g. Obsessive Compulsive Personality Disorder (OCPD) or Organic Personality Disorder.

4.2.3.43 Information was available within the health record to construct an adequate clinical formulation that could have been reviewed and updated as it came to the attention of the clinical team, for example:

- Predisposing personality traits, meticulousness, perfectionism
- Difficult interpersonal relationships
- Excessive demands placed on partners
- Reported 'terrible temper'
- Impact of road traffic accidents (1988 and 2002)
- Increase in OCD symptoms post brain traumas
- Increased anxiety
- Relationship breakdowns history
- Loss of friends, social networks, loss of job
- Increased irritability
- History of threats to harm self, harm others
- Increasing rigidity of routines

- Loss of Care Coordinator regarded as a sympathetic support by Mr B
- Loss of day service placement (reports of aggression and intimidation)
- Time lapse (of approximately seven weeks) before new Care Coordinator was in post
- Intimidation of others
- Increased social isolation (within his mother's home)
- Impulsive behaviours
- Increasing conflict laden relationships within his mother's home
- Rituals becoming increasing time consuming
- Increased anxieties about his possessions being moved. Mrs A reports that her husband would deliberately undertake these acts to 'wind her son up'
- Historical lack of treatment compliance (including cognitive therapy and medication)
- Fear of loss of tenure at his mother's home
- Disclosure April 2007 to Care Coordinator – 'he hates people moving his things'
- Mother's collusions and minimisation of her son's behaviours
- The relationship between setting condition of domestic conflict, increased stress, exacerbation of compulsions, the impulsivity and low emotional control threshold (possibly brain trauma related), and the propensity to give way to aggression and violence.

4.2.3.44 The inter-relationship with these operating dynamics if consolidated into a meaningful formulation would have no doubt served to better inform the clinical risk assessment process. Conversely a failure to assimilate this information into a meaningful assessment potentially weakened any endeavours of identifying or predicting risk. The independent investigation team felt that, in the absence of a clinical formulation, it is difficult to know whether the team were aware of the possible factors in terms of diagnoses that were interfering with recovery. However it does appear that the psychiatrists involved in his care and treatment were well aware of the influence of his pre morbid obsessional nature, the impact of his head injury and the influence of his mood problems as well as the possibility that at times he was bordering on psychosis.

4.2.3.45 From a review of the documentation made available to the independent investigation team and feedback provided at interviews there appear to have been a number of weaknesses in team communication and joint working.

4.2.3.46 With reference to the day service, information had been shared (e.g. via the professionals' meeting 09 March 2006) regarding Mr B's intimidating and aggressive behaviour towards other users of this service. Mr B at this meeting is reported to have disclosed to services his concerns about his step-father abusing his mother. Whilst it was agreed that Mrs C, Care Coordinator, would follow this issue up with Mrs A there appears to have been no further exploration by the CMHT into Mr B's aggressive behaviour – e.g. no further enquiry with this day service or others appear to have taken place regarding the fundamental nature of Mr B's

aggressive behaviour, whether the behaviour was situation specific or occurring in other environments or prompting discussion within the CMHT with day service or the family regarding the implications for risk of violence towards others.

4.2.3.47 It may have been the case that the CMHT had assumed Mr B's neuropsychological assessment and subsequent care responses had been appropriately responded to within the day service. Hence there may have been an over-estimation of the nature, capacity and capability of the day service.

4.2.3.48 On the 14 March 2006 Mr B's care plan is reported to have been discussed further with the day service, at that meeting they had given one month's notice before he would be discharged from the service. Mr B's Care Coordinator did discuss this with Mrs A, who had in response expressed concern about the impact of this on both herself and her son. The issue of Mr B's recent aggressive behaviour does not appear to have been taken account in terms of the proposed discharge planning with day service and the CMHT. Whilst discussion and planning had taken place regarding proposed alternative occupation, the employment service project resulted in no occupational activity and subsequently ended. The proposed local mental health charity and befriending support mechanisms also failed to provide any support. In sum the onus appears to have been left to Mr B to provide himself with more of the same health and fitness routines, the very focus and activity that Mr B was already preoccupied with and a feature of his obsessive rituals. No one appears to have explored with Mr B the relationship between exercise and his obsessive anxieties. There was, from a review of the documentation, no evidence of a clear relapse prevention strategy. No one appears to have asked Mr B or his mother or stepfather what a typical day looked like for Mr B.

4.2.3.49 With reference to the employment service project, Mr B appears to have had a very clear (albeit narrow) aspirational objective in terms of what he wished to do by way of meaningful occupation. This view was re-iterated by Mr B when interviewed by the independent investigation team. Mr B was very clear that the only occupation he would consider was to work as a collector of charitable donations, collecting these goods along with the charity's van driver. There appears to have been no re-evaluation of Mr B's occupational activity schedule once he was discharged from the employment service project. Given this lack of other occupational goals being developed, there again appeared to have been a reliance on Mr B's own resolve to find activities – which were almost exclusively cycling and attending the gym. It is noteworthy that when Mr B was asked by the independent investigation team how he would spend a typical day he reported that he would arise very early in the morning, get himself ready to go out cycling or to the gym, often as early as on the road for 05.30 am, arrive back home for lunch then go to the gym. He reported that he would spend time in his room listening to music or watching TV, often to keep out of the way of Mr A. He would then retire to bed early in the evening.

4.2.3.50 The CMHT appear not to have discussed with Mr B the potential negative catalyst this routine could be for his psychological well being. Mr B also reported to the independent investigation

team that he would hear, whilst in his room, his mother being subjected to physical abuse by Mr A. The recognition of the potential for Mr B's increased social isolation, increased pre-occupation with his keep fit activities, the increased inter-personal conflict and high expressed emotion within the household appears not to have been recognised or considered as precursors to Mr B's relapse.

4.2.3.51 The CMHT did not recognise the potentially vulnerable situation of both Mrs A and Mr B and this was clearly a missed opportunity to enable a more in-depth multi-agency review of the risks. There is clear documentary evidence within Mr B's health record of disclosure by both Mr B and Mrs A of physical abuse by Mr A towards his wife. In addition to which Mr B himself informed Mrs C, his Care Coordinator at the time, that there had been problems of the previous weekend with his stepfather physically abusing his mother and that the police had been called. On the 30 June 2006 Mrs A had left a telephone message for Mrs C that there had been a fight between Mr B and his stepfather. This information should have prompted at least discussion within the CMHT and referral for Vulnerable Adults Safeguarding review. There was a clear requirement in the Trust's Vulnerable Adults procedure at the time of this reported incident.

4.2.3.52 The CMHT did support Mrs A to access the Carer's Association albeit the carer's assessment did remain incomplete on the file. There does however appear to have been no ongoing follow-up or record of how the initial contact had progressed. Interview responses to the independent investigation team suggested that Mrs A herself may have chosen not to progress this line of support further.

4.2.3.53 There were a number of communication issues within the CMHT which no doubt contributed in part to a poorer understanding, assessment and care planning being provided to Mr B and his family. In particular, the Consultant Psychiatrist reported to the independent investigation team that he had no knowledge of the historical incidents and 'risky behaviours' displayed by Mr B. The Consultant Psychiatrist also reported that he had been unaware of Mr B's CPA reduction from enhanced to standard and the pending discharge from the CMHT. Decisions he reported 'he would have been concerned about'. There appears to have been no multi-disciplinary team discussion about the appropriateness or otherwise of the decisions made within the CMHT regarding Mr B's care and treatment. It is of note that at an out-patient appointment attended by Mr B and his mother on 27 June 2006 there was no discussion about the recent domestic violence, despite the call from Mr B to Mrs C on 26 June 2006 in which he reported his step-father, Mr A, physically abusing his mother. No home circumstances assessment or report appears to have been undertaken at any point subsequently.

4.2.3.54 The CMHT Manager Mr G reported that clinical supervision was provided to case co-ordinators by him but that it was down to the care co-ordinator, which cases to present or discuss. The CMHT manager stated that at the time case notes were not always brought to these supervision sessions.

4.2.3.55 The CMHT Manager reported that at the time of the Mr B case historical risk documentation was poorly recorded. He confirmed that whilst the core risk assessment documentation had not assisted the risk assessment process, there were ongoing difficulties with the risk management planning templates.

4.2.3.56 It has to be acknowledged that the reluctance of Mr B to disclose fully his OCD anxieties and the collusion at times between Mr B and Mrs A in terms of minimising the domestic abuse and apparent high expressed emotion within the household may have in part at least served to lead the CMHT to underestimate the associated risks. Equally, the CMHT do not appear to have inquired into the domestic circumstances.

4.2.3.57 The fact that the CMHT had not appreciated the need for neuropsychological assessment, perhaps reflected the lack of training on comorbidity with brain injury. Dr I (Consultant Neuropsychologist at the time) in his report to the Trust's internal investigation team makes the point that 'there was a need to have a comprehensive neuropsychological assessment of this gentleman to see where the neuro-rehabilitation would have been targeted. Once it would have been known where the deficits were, specific targets could have been developed and Mr B could have been sent to a facility where neuro-rehabilitation was possible. The fact that Mr B was not referred to a neuropsychology service post the voluntary sector day service episodes have to be regarded as a major weakness'. It has to be acknowledged that the proposed explanations regarding Mr B's failure to successfully engage in cognitive therapies, his reported aggressive behaviours and reckless behaviours towards others may have been based on an inadequate knowledge base. No care pathway or best practice guidance on dealing with a comorbid brain injury and mental disorder was available within the Trust when requested by the independent investigation team. It is acknowledged that this work had been commenced at one point but had not been completed following the author leaving the employment of the Trust.

4.2.3.58 In terms of joint working and seeking specialist advice for Obsessive Compulsive Disorder, the NICE Guidance (2005) advocates access to specialist OCD multi-disciplinary advice. This did did not take place. From discussions at interview the independent investigation team was not able to ascertain a robust working knowledge of this Guidance among these interviewees. When comparing Mr B's care plans and the requirements in the NICE guidance there were notable deficits regarding assessment, consultation with specialist advisors, engagement of families, referral to voluntary support groups and understanding the import of rituals and compulsions with others.

4.2.3.59 NICE Guidance advocates that an offer of assessment of the carer's social, occupational and mental health needs should be made, particularly when the patient's disorder is moderate, severe or chronic. This offer does not appear to have been followed up by the CMHT.

4.2.3.60 The use of family based approach in supporting the family does not appear to have been considered by the team. It is noteworthy that the secure service currently providing care and

treatment for Mr B considers undertaking therapeutic interventions being more successful if undertaking the role jointly with Mr B and Mrs A.

4.2.3.61 Mrs D reported at interview that there was no case note summary, no core risk assessment information. In addition to which Mrs D reported that care plans were extensive and not summarised. Mrs D stated that, given the case had been scheduled for discharge, it was not necessary to look back over the case files. Mrs D's decision-making rationale she reports was based on the direction given to her by her line manager, Mr G, and on the fact that there had been little case activity. The indication was that Mr B did not require continued mental health service input. Mrs D concluded that she had been told by her line manager Mr G that a number of the previous Care Coordinator's cases should be closed and the this case was one of them.

4.2.3.62 A fundamental weakness that resulted in the CMHT's impaired professional judgment and clinical decision making appears to be the failure to maintain an accurate, updated risk chronology, risk assessment and risk management plan. A review of Volume 2 of Mr B's health record contains a risk chronology report between 1984 and 2005. This log identifies 12 risks including five risks to others. Volume 3 of Mr B's health record has a risk chronology, which cites only three incidents between 1981 and 2005, two of which were risks to others. These documents demonstrate significant inadequacies at the time relating to the recording of incidents and clinical risks. It is highly unlikely that the information was used in any meaningful way by the clinical team to identify, assess and as appropriate develop suitable clinical risk management plans.

4.2.3.63 When the clinical team were asked about the process of multi-disciplinary team decision-making undertaken at the time of the incident both the Consultant Psychiatrist and CMHT manager reported that team members could bring cases they wished to discuss with MDT colleagues to a weekly meeting. However, the decision regarding which cases to bring for discussion was left with the respective clinicians. It is of note that team members report that there were not always formal minutes taken or archiving of these records in place at the time. The CMHT manager reported that individual clinicians were required to make an entry in the respective service user's health record following such a discussion. However, it was reported that this was not always undertaken, nor were monitoring mechanisms in place to provide assurance that this practice requirement was adhered to. It was reported by the CMHT Manager that individual clinicians adopted different documentation systems for recording service user information.

4.2.3.64 After Mr B had been found wandering barefoot on a nearby motorway in May 2005 the police made a referral to the Vulnerable Adults/Safeguarding team. There was no follow-up recorded. One suggestion proposed by the internal investigation team was that this may have been superseded by the Mental Health Act assessment following the Section 136 detention on 31 May 2005. None the less there appears to be no reference to Mr B being subject to a response from the Adult Protection Team. (See also para. 4.2.3.19)

4.2.3.65 It is noteworthy that Mrs A's report to the CMHT (30 June 2006) regarding the fight between Mr B and Mr A should have also prompted a multi-disciplinary team discussion about, if not actual referral to, the Vulnerable Adults-Safeguarding Team. No further action regarding Safeguarding appears to have been taken. (See also paras 4.2.3.23, 4.2.3.52)

4.2.4 Service Delivery Problems

4.2.4.1 The following service delivery problems were identified.

4.2.4.2 Specifically, the independent investigation team concluded that access to a specialist OCD multi-disciplinary team for direct input or advice may have assisted in an increased prediction of risk. The National Institute for Health and Clinical Excellence (NICE) Clinical Guideline 31, (2005) *Obsessive Compulsive Disorder - Core interventions in the treatment of obsessive compulsive disorder (OCD) and body dysmorphic disorder (BDD)* – advocates that each Primary Care Trust, mental health care Trust and children's Trust that provides mental health services should have access to a specialist OCD/BDD multi-disciplinary team offering age-appropriate care. Such a team would:

- Increase the skills of mental health professionals in the assessment and evidence-based treatment of people with OCD or BDD
- Provide high quality advice
- Understand family and development needs
- As appropriate conduct expert assessment and specialist cognitive-behavioural and pharmacological treatment.

4.2.4.3 NICE guidance further advocates that, where appropriate, the provision of accurate information in an appropriate format on the current understanding of OCD from psychological and/or biological perspectives should be made available to people with the disorder and their families/carers. This information would assist them to understand the nature of the symptoms. This information may have been particularly useful to Mr A who is reported (by Mr B and Mrs A) to have repeatedly goaded Mr B regarding his behaviours. His response to Mr B's anxieties and behaviours may in part have been attributed to a lack of understanding of the OCD condition. This simple intervention does not appear to be been actioned. Mrs D reported that Mr A was rarely even engaged, giving the impression that he wished not to be involved with any health care professionals. The opportunity to develop a collaborative approach with Mr B's step-father appears not to have been pursued.

4.2.4.4 It is of note that Mrs D, the Care Coordinator, was at this time an Approved Social Worker and did not have a medical or nursing background. When Mr G, the CMHT Manager, was asked by the independent investigation team if a Community Psychiatric Nurse may have been a more appropriate care coordinator he reported that the size of the team at the time and case load demands made this not possible.

4.2.4.5 Mr G, the CMHT manager, confirmed that he had assessed the case for closure, particularly given the competing priorities for resources and given the fact that Mr B's case was seen as requiring minimal input. Mr G commented that 'they did not pick up on what was going on and focused too much on what Mr B was presenting'.

4.2.4.6 A review of Mr B's notes and care plan demonstrated no reference to any local clinical guidelines, care pathways or protocols to be followed with an individual diagnosed with OCD. The independent investigation team were able to confirm from discussion with interviewees that such care pathways had not yet been developed.

4.2.4.7 The independent investigation team from discussion with interviewees established that there was no care pathway established for individuals with traumatic brain injury or those who have acquired brain injury, nor has a specialist neuropsychology service been developed within the Adult Services of the Trust to date.

4.2.4.8 The National Service Framework for Long Term Conditions (March 2005) identifies eleven Quality Requirements (QRs), which are based on currently available evidence, including what people with long term neurological conditions reported about their experiences and needs:

- QR2 Early recognition, prompt diagnosis and treatment – 'People suspected of having a neurological condition are to have prompt access to specialist neurological expertise for an accurate diagnosis and treatment as close to home as possible'.
- QR4 Early and Specialist rehabilitation – 'People with long term neurological conditions who would benefit from rehabilitation are to receive timely, ongoing, high quality rehabilitation services in hospital or other specialist settings to meet their continuing and changing needs. When ready, they are to receive timely, ongoing, high quality rehabilitation services in hospital or other specialist settings to meet their continuing and changing needs'.
- QR5 Community rehabilitation and support – 'People with long term neurological conditions living at home are to have ongoing access to a comprehensive range of rehabilitation, advice and support to meet their continuing and changing needs, increase their independence and autonomy to help them live as they wish'.
- QR6 Vocational rehabilitation – 'People with long-term neurological conditions are to have access to appropriate vocational assessment, rehabilitation and ongoing support, to enable them to find, regain or remain in work and access to other occupational and educational opportunities.'
- QR10 Supporting families and carers – 'Carers of people with long term neurological conditions are to have access to appropriate support and services that recognise their needs both in their role as carer and in their own right'.
- QR11 Caring for people with neurological conditions in hospital and other health and social care settings – 'People with long term neurological conditions are to have their specific neurological needs met whilst ensuring treatment or care for other reasons in any health or social care setting'.

4.2.4.9 The point is made by the Consultant Neuropsychologist's report provided at the request of the internal investigation team that, in his professional opinion, 'there was a need for Mr B to have a comprehensive neuropsychological assessment to see where neuro-rehabilitation would have been targeted. Once it would have been known where the deficits were, specific targets could have been developed and Mr B could have been sent to a facility where neuro-rehabilitation was possible. The fact that Mr B was not referred to a neuropsychology service post day service episodes has to be regarded as a major weakness.' The independent investigation team considered that this *might have been* a weakness in the care provided to Mr B.

4.2.4.10 It is apparent from the Trust's internal investigation report and supported by interviewee comments made to the independent investigation team that the issue of staff training, in particular the lack of specific training with regard to treatment resistant OCD, and co-morbid brain injury and mental disorder was a significant factor.

4.2.4.11 The lack of a single health care record undoubtedly contributed to fragmented communications as well as the fact that the Consultant Psychiatrist was not located with the rest of the team and the delay in appointing a new care coordinator for Mr B when Mrs C left the service.

4.3 Contributory Factors

4.3.1 The independent investigation team identified the following contributory factors, with reference to full details where appropriate.

4.3.2 Mrs A appears not to have reported (prior to the incident of 14 May 2007) the issue of psychological abuse of Mr B by Mr A. If she had done so this could have been an appropriate reason for referring Mr B via the 'Safeguarding Vulnerable Adults' procedure. This missed opportunity could have then led to a multi-agency review at which Mr A's previous conviction history of violent offending (i.e. conviction for common assault at Swindon Magistrates' Court 08 September 2003) would have resulted in raised awareness of this risk area.

4.3.3 Mr B is reported by his Consultant Psychiatrist to have a history of poor compliance with treatment interventions, including medication. The police toxicology report on Mr B shows no indication of medication or other substances in his blood at the time of the incident.

4.3.4 Mr B's Consultant Psychiatrist, when asked by the independent investigation team if a referral for neuropsychological assessment would have been helpful, stated that in his opinion there had been no indication for the need to make such a referral. He added that a number of experienced clinicians from multi-disciplinary backgrounds had worked with Mr B over the years and had not seen the need to request such an assessment. The Consultant Psychiatrist reported that had such a request been made by colleagues he would have been happy to make such a referral via Mr B's GP. However, the independent investigation team consider that it was possible that such a referral might have enhanced the care and treatment of Mr B.

4.3.5 It is noteworthy that balanced against the documented disclosures by Mrs A and also Mr B of alleged violence in the home, both Mrs A and Mr B have also been known to minimise the impact of the level of aggression and domestic violence in other instances. It is notable that Mrs A and her son only disclosed the harassment and abuse which Mr A had subjected Mr B to, following the incident on 14 May 2007. Had that information been disclosed previously it would have afforded the opportunity for the CMHT to refer Mr B via the Vulnerable Adults procedure. A further opportunity would have been available for a full multi-agency risk review.

4.3.6 It is worthy of note that whilst the health record has evidence of Mrs A disclosing her concerns regarding the stress she was encountering living with her son and his stepfather, there is evidence also to demonstrate that Mrs A had continued to collude in minimising her son's behaviours and risks, including his OCD rituals, domestic abuse and tension within the household. At the outpatient clinic appointment with his Consultant Psychiatrist, attended by Mr B and his mother on 19 March 2007, Mrs A agreed with her son's account that his mental state was much improved and that his stability was maintained. No concerns were reported at the meeting regarding the recent violence between her son and husband.

4.3.7 Mrs A's corroboration of her son's account of being well will, no doubt, have contributed to the clinical team's presumption of stability regarding Mr B's OCD and their underestimating the associated risks. Mr B was also reluctant to disclose fully his OCD anxieties. Equally, the CMHT do not appear to have inquired into the domestic circumstances and therefore did not identify the family tensions and conflict. Similarly, they do not appear to have queried the information they were provided and accepted it at face value.

4.3.8 It is of note that when the independent investigation team interviewed Mrs A at her home she minimised the documented accounts of her son's aggressive/violent behaviours. In addition to this, she was of the view that her son presented no ongoing risks to anyone including herself and would be more appropriately cared for and supported by being at home with her.

4.3.9 Mr B appears to have had a very clear (albeit narrow) aspirational objective in terms of what he would wish to do in terms of meaningful occupation. This view was re-iterated by Mr B when interviewed by the independent investigation team. Mr B was very clear that this only work he would consider was to work as a collector of charitable donations, collecting these goods along with the charity's van driver. There appears to have been no re-evaluation of Mr B's occupational activity schedule once he was discharged from the employment service project. Given this lack of other occupational goals being developed, there again appeared to have been a reliance on Mr B's own resolve to find his own activities – which were almost exclusively cycling and attending the gym. (See para 4.2.3.1 for full details)

4.3.10 The CPA was used to support Mr B , there is evidence within the CPA documentation to demonstrate consultation with and the ongoing involvement with Mrs A, and other voluntary agencies, including day service, an employment service and a local mental health charity. There

is no evidence that the CMHT investigated if there was any local self-help support group for people with OCD, to which they could have referred Mr B.

4.3.11 Mr A is reported by Mrs D to be a person who was 'not easy to engage' and would 'always go into the other room'. There does not appear to have been any attempt to engage Mr A in discussion about the impact of Mr B's behaviours within his home.

4.3.12 In summary it appears that the CMHT could have done more to appreciate the complexity and severity of Mr B's OCD, in turn the subsequent clinical decision-making was based on inadequate if not faulty constructs. These contributory factors in summary include:

- The CMHT did not recognise the potential of a neuropsychological assessment to inform and underpin treatment
- The CMHT did not undertake appropriate clinical risk management
- The CMHT did not consider NICE guidance regarding OCD – albeit there was no local guidance based on this work
- The CMHT did not engage the family as a whole, nor appreciate the complex family dynamics, including domestic violence – although they were not made aware of the full complexity of the domestic situation
- The CMHT could have worked better as a collaborative multi-disciplinary team
- The CMHT could have ensured an appropriate relapse prevention plan
- The CMHT could have undertaken a multi-disciplinary clinical formulation to inform the psychiatric assessment and provide an appropriate care and treatment rationale
- A lack of training and underpinning knowledge within the team sufficient to respond to the clinical presentation and associated complexities.

4.4 Notable Practice

4.4.1 The independent investigation team accept the items of notable practice identified in the internal investigation report. These were as follows.

- Prompt response to crises in 2004 and 2005
- Two episodes of specialist Cognitive Behavioural Therapy as treatment for OCD

4.5 Common themes

4.5.1 The independent review team have completed a review of an internal investigation of a homicide which was undertaken by the Trust in 2003. The team's review was undertaken in December 2010: NHS South West requested that the team identify any similar themes within the two incidents. These included:

- The failure to complete a carer's assessment
- A failure to identify and explore the issue of domestic violence
- A failure to identify and address any issues of professional accountability by the internal audit team
- The need for effective inter-agency sharing of information regarding clinical risks
- The need to ensure appropriate involvement and debriefing mechanisms for staff involved in serious untoward incident investigations in order to ensure their respective views are sought to inform both the investigation process and subsequent organisational learning
- The failure to include terms of reference and scope within a serious untoward incident investigation report
- The failure to consider the contribution and perspective of the perpetrator.

5 Learning Points for Improving Systems and Services

5.1 In discussion with the independent investigation team there was an acknowledgement by interviewees that there was a failure by the CMHT to recognise the limitations of skills and knowledge base to respond adequately to the complex care and treatment needs of Mr B.

5.2 The CMHT should have been mindful of the need to deliver responsive health care to people with comorbid brain trauma and OCD in accordance with the evidence-based/best practice guidance available at the time. There is a recognition that this was not adequately undertaken by the Team at the time. The Trust's own internal investigation identifies the principal reasons for these inadequacies.

5.3 It is of note that the issues of access to specialist advice and support to CMHTs from OCD specialist multi-disciplinary teams has not yet been determined within the Trust.

5.4 At interview with the independent investigation team Dr F acknowledged that the development of a clear treatment and care pathway for this service user group would be appropriate but as yet had not been undertaken.

5.5 With reference to the issue and importance of neuropsychological assessment, whilst this had been appropriately acknowledged with the Trust's integrated homicide action plan the Trust has no consultant neuropsychologist in post at present in the Adult SBU. Information provided to the independent investigation team was that the 0.8 whole time equivalent funded (vacant) post based in Bristol would be inadequate to meet the Trust's Adult Services Consultation and Clinical case load needs across the whole of the Trust area. However, filling this vacancy is a priority for the Trust as a Specialist Neuropsychologist will be able to provide consultation and advice to clinical psychology staff across the Adult SBU.

5.6 The Trust has also acknowledged within the Integrated Homicide Action Plan, the need for joint CPA processes to be established between Mental Health Services and the Neurological Rehabilitation services and other agencies. The update on the Action Plan (November 2009) reports the outstanding action as 'Local negotiations have resulted in no opportunities for developments. The issue will be taken to the commissioning discussion for 09/10'.

5.7 It is of note that the Trust had begun to develop (2008) *'Good practice guidance for staff on the care and treatment of people with comorbid traumatic brain injury and mental disorder'*. At the time of the independent investigation, this work remains in draft status due to the lead for this work (Consultant Neuropsychologist) having left the employment of the Trust. It was acknowledged by the Trust's Director of Psychology that this work needed to be completed as soon as possible.

5.8 The need for good multi-disciplinary collaborative working underpinned by the use of clinical formulations had been recognised by the Trust and is now incorporated within the Trust's ICPA procedure. However, the need for ongoing periodic assurance that this requirement is a

fundamental characteristic of a CMHT's working practice should not be underestimated e.g. Systems Monitoring Process/Clinical Audit.

5.9 The issue of staff having access to the appropriate level of Safeguarding training e.g., 'Investigating Safeguarding Allegations' was reported to the independent investigation team as a training need inadequately met due to insufficient training opportunities being made available. It would seem prudent to ensure this issue is appropriately monitored and addressed as required.

5.10 The issue of inappropriate handover protocols (particularly by care coordinators) was recognised within the Trust's internal investigation. This has been addressed as part of the Trust's current Care Programme Approach and Risk Policy and associated procedures. In addition to this the Trust's clinical supervision process now has a monitoring mechanism (via senior managers) which should provide an additional mechanism to ensure the maintenance of good handover processes.

5.11 There has been a recognition by the organisation that a single health care record is of paramount importance to minimise some of the system failures outlined within the Trust's internal investigation report. To this end the Trust has clear procedural guidance on the use of a single health record. In addition to this, the migration to a single electronic patient record has been planned for implementation in 2010. Individuals interviewed by the independent investigation team recognised the potential benefits from an electronic patient record system to support more efficiently and effectively the monitoring and audit functions.

5.12 The Trust's *NICE Guidance Implementation Policy* (November 2008) Section 8.4 Monitoring and Auditing states that:

"Auditing compliance on an ongoing basis – Strategic Business Unit (SBU) clinical service directors have a joint responsibility to develop an agreed clinical audit …. The SBU plan should include regular clinical audits of NICE guidelines on a regular basis. Where audit performance shows non or partial compliance with a NICE Guideline, the NICE Guidelines implementation plan should be reviewed and amended to address any areas of non-compliance."

5.13 It would seem appropriate where a serious untoward incident highlights a failure to adhere to NICE guidelines in a specific team or service that this should prompt an audit of the guideline's implementation in other similar service delivery teams.

5.14 Where a serious untoward incident investigation has identified system failures it would seem prudent for the organisation to determine if any clinical or organisational risks are evident. Having identified such risks these should be managed in accordance` with good risk management housekeeping – e.g. evaluating controls, treatment plans and appropriate risk weighting etc.

5.15 Domestic violence was a significant factor in Mr B's home circumstances. He himself reported to the independent investigation team that knowing his mother was being subjected to serious abuse was a significant source of distress to him. It is noteworthy that the issue of domestic violence was known to the CMHT and documented over time within Mr B's health record. The implications of this domestic violence/abuse on Mr B and Mrs A (Mr B's main carer) were not explored. The issue of domestic violence awareness training was discussed by the independent investigation team with witnesses. All acknowledged the inadequacies in appropriately recognising and responding to the issue. Interviewees commented on the fact that Domestic Violence was an element of the Safeguarding Awareness training but that the issue may be buried in the wider content of the training. It was reported by all interviewees that the issue of domestic violence and practitioners' responsibilities in respect of suspected or actual incidents warranted further guidance/training.

5.16 With reference to clinical risk management the Trust's internal investigation appropriately identified the CMHT's weakness in terms of incident chronology management, the limitations of the clinical risk management assessment process and risk mitigation plan. The lack of appropriate clinical risk management in the case of Mr B had been an ongoing inadequacy demonstrable within the documentation as being evident for a number of years, and therefore could not be attributable to any individual. Rather it was a failing within and by the whole CMHT. Reviewing the Trust's training calendar 2010-2011, there is training provision made for 'The manager's role in developing CPA and care pathway processes and working collaboratively with risk'. The learning objectives do not appear to focus on or provide awareness training with regard to best practice in managing risk. When the independent investigation team, discussed the issue of best practice in the assessment and management of risk (to self and others in mental health services), some interviewees were not aware. It would seem prudent for the training needs of CMHT practitioners to be evaluated in terms of delivering best practice for effective risk management. The Department of Health (2007) publication *Best Practice in Managing Risks – Principles and Evidence for best practice in the assessment and management of risk to self and others in Mental Health Services* would be an appropriate point of initial reference from which to develop a knowledge and skills framework for practitioners. The Royal College of Psychiatrist's Report (2008) *Re-Thinking Risk to Others in Mental Health Services* provides an appropriate adjunct to such curriculum planning.

5.17 Given the CMHT's involvement with the day service and the issues becoming apparent regarding Mr B's reported intimidating and aggressive behaviour at the Centre, it would seem appropriate to look at the need to develop inter-agency risk management protocols to ensure information sharing about potential risks.

5.18 Reviewing the Trust's policy and procedure index there does not appear to be any procedural guidance on:

- Suicide and serious self-harm

- Clinical risk management (specifically with reference to risk weighting matrix – likelihood x consequence)
- CMHT's responsibility towards actual or suspected domestic violence
- Medication non-compliance (reducing the risks).

5.19 It would be appropriate to ensure that procedural guidance on these practice areas is available within the Trust.

6 Recommendations

6.1 Service Development

1 That a treatment and care pathway for service users with a diagnosis of Obsessive Compulsive Disorder is established by the Trust in accordance with NICE Guidelines (CG31).

2 That the provision of Mental Health Team's access to specialist advice (in accordance with CG 31) is addressed by the Trust and commissioners.

3 That a treatment and care pathway for service users with a diagnosis of comorbid brain injury and mental disorder is developed by the Trust in accordance with NICE Guideline (CG56).

4 That the Trust's resource requirements to provide neuropsychological assessment services (including consultant assessment and case load management) are determined and considered as part of the Trust's business planning process.

5 That the issue of the Trust's Mental Health Services having partnership working agreements with Neurological Rehabilitation services be reviewed with commissioners as a service delivery priority.

6 The Trust make agreements with other agencies about how risk information will be shared with each other to ensure that critical information is not lost in the risk assessment and management process. This might include local authority, criminal justice, private or voluntary sector organisations.

7 Where a serious untoward investigation identified system failures, timely assurance should be sought by the Trust (e.g. via clinical audit) to ensure such failures are not apparent within other teams.

8 The Trust should consider the potential clinical and organisational risks following any serious untoward incident investigation. Where appropriate:

- these risks should be 'weighted' (assessing the significance of the risk relative to other risks);
- the adequacy of controls (e.g. staff training, support and supervision levels) should be assessed;
- treatment plans should be developed to reduce the risks.

9 The Trust should consider whether or not the risks identified in this serious untoward incident investigation are evident elsewhere in the organisation, and assure themselves that there are no significant risks still outstanding which have not been addressed.

10 Where other agencies are working with or have a significant history of working with a service user who is involved in a serious untoward incident investigation, the internal investigation team

should ensure their respective views are sought to inform the investigation process and subsequent organisational learning. This might include local authority, criminal justice, private or voluntary sector organisations.

11 To consider how the organisational learning from the Trust's Mr B serious untoward incident internal investigation report can be most effectively disseminated Trust-wide to key stakeholders who may not as yet have had the opportunity to access this information.

6.2 Audit

12 That the use of clinical formulations within CMHTs be included in the appropriate Strategic Business Unit's clinical audit programmes.

13 That the Trust's clinical supervision procedure within CMHTs continues to be included within the appropriate Strategic Business Unit's Clinical Audit Programmes.

14 That implementation of the policy and procedures regarding 'Investigating Safeguarding Allegations' be included in the appropriate Strategic Business Unit's Clinical Audit Programmes.

6.3 Training

15 That the issue of appropriate grades of staff having access to the required level of training in 'Investigating Safeguarding Allegations' be reviewed to ensure that access opportunities and uptake for this training are adequate.

16 That the Trust reviews the training needs of Mental Health Teams with regard to awareness of and responsibilities as health professionals when Domestic Violence is alleged, suspected or observed.

17 That CMHT's training needs regarding clinical risk management in accordance with evidence-based/best practice are evaluated. The provision of appropriate skill update training should be developed as required.

18 That the Trust ensures that health care professionals are not given responsibility for service users with Obsessive Compulsive Disorder unless and until they have received appropriate training in the condition, its care and treatment.

6.4 Policy and Procedures

19 That the Trust consider the need to develop Trust procedural guidance on the following (if this has not been done prior to the completion of this report):

- Suicide and serious self-harm
- Clinical risk management and the CMHT's responsibilities with regards to actual or suspected domestic violence
- Medication non-compliance.

6.5 Internal Serious Untoward Incident report

20 That the issue of staff accountability be a reporting criterion clearly acknowledged within subsequent serious untoward incident investigations.

21 In accordance with the Trust's current procedural guidance, Terms of Reference for a Serious Untoward Incident investigation should be provided to the investigation team and clearly stated within the reports.

22 The National Patient Safety Agency (NPSA) Incident Decision Tree should be considered by an internal investigation team when determining possible system or individual failures within the organisation.

23 To provide Mrs A with the opportunity to receive the Trust's findings, recommendations and actions taken from the Mr B serious untoward incident internal investigation report.

6.6 Internal Investigation Report Recommendations

A number of recommendations were made by the internal investigation report. The independent investigation team were assured by the Trust's Head of Risk and Compliance that most of these recommendations had been implemented. These were recommendations regarding the care and discharge planning, carer's assessments and the involvement of families and carers to inform care and treatment decisions. This report does not replicate recommendations on those subjects, but focuses on recommendations which had not been implemented at the time of the interviews and on issues where there were no recommendations in the internal review.

7 *The adequacy and appropriateness of the Internal Investigation*

7.1 Review of internal reports

7.1.1 The independent investigation team reviewed:

- The Initial Management Investigation report for serious untoward incidents (including deaths)
- The Trust's Adverse Incident Report
- The Trust's internal investigation report – Root Cause Analysis Report.

7.1.2 The Trust's initial management report for serious untoward incidents (including deaths) was produced by Mr H, a service manager independent of the service providing care and treatment to Mr B. The report was completed in a timely manner, dated 16 May 2007. The report provides:

- A summary description of the incident
- The date and time of the incident
- A time line summary of events (September 2006 to date of incident)
- Relevant background information
- Acknowledgement of previous care plan dates
- Acknowledgement of inadequate risk assessment review documentation
- A brief analysis of events pre and post incident.

7.1.3 The following sections of the Trust's reporting template were not completed:

- Issues identified, lessons learned
- Recommendations
- Further investigation required (None/ Team Audit/ Independent Root Cause Analysis).

7.1.4 It may have been appropriate to enter some initial response to these sections, e.g. 'Unable to provide requested information at this point' rather than leave these sections blank.

7.1.5 The initial management report met the Serious Untoward Incident procedural requirement of the time. The report was adequately prepared.

7.1.6 The Trust's Adverse Incident Report was completed by Mr B's Care Coordinator Mrs D and dated 15 May 2007. The documentation requirements were fully completed as appropriate. However, Section E of the Adverse Incident Report: What Happened requires a summary of the incident. A prompt note is made to 'Take care to record FACT only NOT opinion' (original emphasis). The summary report states only 'Mr B murdered his stepfather Mr A.' It was however not known at that point the status of any offence charge or subsequent conviction. It would have been more accurate to report the fact that Mr B had been arrested by the police in connection with the death of his stepfather.

7.1.7 The Trust's Root Cause Analysis report (internal investigation report) is dated 08 October 2007. The internal investigation team was comprised of three senior clinicians all of whom were employed by the Trust. All the team had significant clinical experience and two had previously received Root Cause Analysis training.

7.1.8 The report provided evidence of appropriate Root Cause Analysis tools, including time-line of events grid, treatment history, '5 Why Questions', fishbone or Ishekawa Framework.

7.1.9 Witness statements and interviews with key personnel were undertaken with:

- Mrs A (Mr B's mother)
- Individual members of staff including who had provided treatment to Mr B , including Trust employees and his GP.

7.1.10 Care management documentation reviewed by the internal investigation team included:

- Mr B's health records
- Internal reports (adverse incident report, internal management report)
- Medical reports completed after the Incident.

7.1.11 The report identified six Care Delivery Problems (defined as problems that arise in the process of care, usually actions or omissions by staff). The Care Delivery Problems identified by the internal investigation were identified as:

- Failure to follow the Trust's Vulnerable Adults Procedure (31 May 2005)
- Lack of a carer's assessment (05 April 2006 and at other times)
- Failure to accurately record and investigate reported violent incidents
- Lack of accurate updated risk assessment/management plan
- Lack of clear care planning goals with change from Enhanced to Standard ICPA
- Lack of access to neuropsychology (a failure to refer for neuropsychology assessment).

7.1.12 In addition two Service Delivery Problems were identified (defined as 'acts or omissions during the analysis of this patient's safety incident but that are not associated with the direct provision of care'). These were:

- The capacity of the CMHT (its small size resulting in the team's difficulty in providing cover for staff vacancies)
- Staff knowledge (inadequate knowledge base with regard to both OCD and brain injury).

7.1.13 The internal investigation identified contributory factors in four areas, which included:

7.1.13.1 Patient factors:

- The clinical team did not identify issues around Mr B's motivation to engage in treatment as an objective in the care plan

- Mr B's reluctance to discuss the detail of his OCD symptoms with staff which meant that the CMHT were unable to fully understand his OCD
- Mr B s presentation as childlike, which seemed to have resulted in staff discounting his documented threats of harm to others and to see him as not a risk to others
- Reducing the risk of Mr B's self-harm became a major goal of the care plan, which appears to have deflected staff attention from the potential for Mr B's risk to others.

7.1.13.2 Task factors:

- Staff did not follow Trust procedure in completing risk assessments and, crucially, risk information was not handed over between staff or between different sets of notes
- Risk information not collected formally from Mrs A, although there were many discussions with her covering risk
- Failure to complete the carer's assessment documentation
- Failure to adopt a family based approach to care, resulting in a limited understanding of the family dynamics
- Lack of local family therapy clinics
- Withdrawal of services – time lapse in reallocation of a new CPA care coordinator; the replacement care coordinator was relatively inexperienced
- The Specialist Day Service – Mr B's discharge from the service, Mr B's reported intimidating behaviour, and Mr B's and Mrs A's self-reporting of the impact of losing such as service.

7.1.13.3 Communication factors:

- Mrs A's failure to report Mr A's goading of Mr B
- Mrs A's disclosure of the poor relationship between herself and her husband, which degenerated on occasions to domestic violence. The reasons for the couple considering divorce were not made clear within the file
- Members of staff were not aware of Mr B's history of posing a risk to others even though this was documented within the care record. Team discussions focussed only on Mr B's risk to himself
- The risk assessment/risk chronology were incomplete, not updated, and not communicated at handover
- Staff did not use a single chronological health file, therefore there were times when staff saw Mr B or his mother without being aware of recent information which had been being recorded by other workers in other files.

7.1.13.4 Education and Training factors:

- Staff had not received specific training in working with treatment resistant OCD. Staff did not have access to specialist supervision. The team had no access to advice on the management of comorbid brain injury and OCD

- The team did not explore the relationship between exercise and Mr B's obsessive fears. Access to specialist supervision would have helped the team to accurately assess and understand this feature of the case
- Staff lacked knowledge and expertise in dealing with comorbid brain injury and mental disorder e.g. awareness that a neuropsychology assessment was essential. The team's assumed that a normal CT scan indicated there were no lasting cognitive deficits from the brain injury.

7.1.14 The report identifies the following care and service delivery problems:

- A failure to follow the Trust's Vulnerable Adult Procedure
- A lack of Carer Assessment
- A failure to accurately record and investigate violent incidents
- A lack of a neuropsychological assessment
- A lack of accurate, updated risk assessment/risk chronology or risk management plan
- A lack of clear care planning goals with a change from enhanced to standard Integrated Care Programme Approach (ICPA)
- A lack of capacity within the Community Mental Health Team (CMHT)
- Inadequate staff knowledge base.

7.1.15 The report identifies root causes, with the key factors being:

- A lack of systematic risk assessment and risk management planning.
- A failure to collect risk information from relatives.
- A lack of a carer's assessment.
- The lack of specialist ongoing input into the management of Mr B's Obsessional Compulsive Disorder.
- A lack of a full exploration of the level of expressed emotion in the house, linking this to Mr Bs previous violent behaviour.
- A lack of awareness among members of the team of the impact and implications of head injury upon Mr Bs behaviour, and a lack of access to specialist neuropsychology advice.

7.1.16 The internal investigation report cites two areas of notable practice in the care that Mr B received, although the report does not provide a rationale for why these are specifically identified as notable practice:

- Prompt responses to crises in 2004 and 2005
- Two episodes of specialist cognitive behaviour as treatment for OCD.

7.1.17 Twenty-one provisional recommendations are made within the report. These were considered by the Trust's Integrated Governance Committee and subsequently approved by the Board.

7.1.18 A glossary of terms and references are appended to the report.

7.2 Observations

7.2.1 The independent investigation team's observations on the Root Cause Analysis Report are:

7.2.1.1 Overall the report is well presented, logically structured and easy to read with an excellent summary.

7.2.1.2 The report provides a very comprehensive, competent and credible analysis and investigation report.

7.2.1.3 The recommendations are clearly stated and provide an appropriate response to the analysis and conclusions.

7.2.1.4 The rationale for the identified 'care delivery' and 'service delivery' problems is clearly explained.

7.2.1.5 The report provides significant evidence of time line/events mapping and the development of a detailed incident chronology.

7.2.1.6 An opportunity was provided to the family of the victim and perpetrator (stepfather and stepson) to contribute to the investigation, which they did.

7.2.1.7 The report has a 'confidential' watermark on each page of the document.

7.2.1.8 No rationale is given for the notable practices identified.

7.2.1.9 Best practice (NPSA, 2008) advocates that internal investigations are completed "as soon as possible after the incident, usually within 90 days". This report was produced almost six months following the incident. Whilst there may have been good reason for the delay the report does not comment on their reasons for this. It is important that this process takes place promptly in order that any changes needed to policy or practice to enhance patient's safety can be formulated sooner rather than later.

7.2.1.10 The internal investigation recommendations are reported as provisional subject to Integrated Governance Committee and Trust Board approval. Whilst such processes are acknowledged, it is none the less important to ensure that additional processing time delays are minimised for the reasons outlined in the previous point. It would have been helpful if a final, dated version of the report had been available.

7.2.1.11 It would be valuable for the report recommendations to have a prioritisation ranking identifying those recommendations regarded as high, medium and low priority with recommended time frames for completion.

7.2.1.12 The internal investigation report does not state the agreed scope of the investigation, nor any Terms of Reference.

7.2.1.13 The report does not explicitly state whether it is a draft or final version.

7.2.1.14 While the report is page numbered there is no computer file path or reference initials.

7.2.1.15 It is noteworthy that the specialist day service provider (acknowledged as a non-NHS provider, and a significant contributor to Mr B's care and support, until 2006) was not interviewed by the internal investigation team. The report does not clarify the reason for this. In discussion with the independent investigation team Dr F

acknowledged that it would on reflection have been beneficial to have interviewed staff from the day service.

7.2.1.16 The report analysis identifies a number of Care Delivery Problems but is silent on the issue of professional accountability. There may have been benefit in considering as part of the process the National Patient Safety Agency's Incident Decision Tree (NPSA, 2004, Root Cause Analysis online toolkit) in determining whether or not these problems arose primarily as a consequence of system failures or poor practice on the part of practitioners.

7.2.1.17 The report recommendations indicate that the action plan was to be discussed with staff who were clinically involved in the care of Mr B. It does not however clarify the need for these practitioners to receive an appropriate debrief. One member of the CMHT reported to the independent investigation team that he had not received any information following the internal investigation and had to seek a copy of the investigation report some months later.

7.2.1.18 It is of note that Mrs A reported to the independent investigation team that she had received no further information about the initial investigation following her meetings with the internal investigation team.

8 Developments in services since Mr B's engagement with mental health services and action taken since the incident

8.1 The Trust has produced a homicide action plan in which recommendations and agreed outcomes from the Mr B serious untoward incident investigation and those arising from other homicide investigations have been integrated into one homicide action plan. This integrated action plan has been subject to performance management monitoring within the Trust and by the Strategic Health Authority. Recommendations were classified into the following sections:

Category of Recommendation	Number of recommendations applicable to Mr B investigation
Clinical care	6
Multi-agency information sharing	2
Formulation	1
Risk assessment	8
Training	3
Service capacity and competences	9
Information sharing	2
Specialist drug and alcohol service	0
Dual disorder strategy and training	5
Early Intervention Services	0
Managing absence staff	4
Managing conflict between teams	2
Relationship between members of staff	1
Family approaches to care	3
Mental health liaison service	*0*
Safeguarding	2

8.2 The homicide action plan (dated 18 September 2009) was provided to the independent investigation team by the Trust Head of Risk and Compliance who identified the vast majority of recommendations as having been completed. The independent investigation team's Terms of Reference have not extended to measuring the adequacy of the implementation of these recommendations.

8.3 At interview the Head of Risk and Compliance confirmed that all recommendations had been completed, with the exception of a small number of recommendations, which were pending completion. The independent investigation team have reviewed these outstanding actions and would make the following observations.

8.4 Recommendation 5 'The Trust should urgently review the recommendations of the NICE OCD Guidance. In particular the recommendations to set up clinical networks for consultancy and

advice available to all staff working with OCD patients should be implemented'. At interview with the Director of Psychology and Trust Lead for Clinical Audit, he reported that there was an outstanding need to establish a specialist advice mechanism for clinicians. He acknowledged that it would be appropriate to develop a care pathway for patients with OCD.

8.5 Recommendation 6. 'The Trust should review available guidance on the care and treatment of people with comorbid brain injury and mental disorder and issue good practice guidance to staff. They should also be aware of the NICE Guidance CG56 (2007) *Triage, Assessment, Investigation and Early Management of Head Injury in Infants, Children and Adults*. The guidance should advise that a neuropsychological assessment should always be obtained to inform the mental health care plan.' The action plan report section 'Outstanding Issues' state 'Local negotiations have resulted in no opportunities for developments. This issue will be taken into the commissioning discussions for 09/10'. At interview with the independent investigation team the Director of Psychology and Trust Lead for Clinical Audit stated that the Trust had funding for a 0.8 w.t.e (whole time equivalent) consultant neuropsychology post. He reported that in order to provide an appropriate level of Consultant or Principal Neurosychological advice and clinical care work the Trust should have 2 posts in Adult Services – one for the West and one for the East.

8.6 A number of other developments in services were also noted including:

- The development of Safeguarding Awareness training for all staff Trust-wide. The CMHT Manager Mr G reported that whilst this was beneficial there were ongoing difficulties in clinicians accessing other levels of safeguarding training e.g. 'Investigation of Safeguarding Incidents'. This was attributed to the inadequate frequency of training opportunities, which are delivered via social services
- The significant awareness raising training for clinicians in psycho-social interventions. Both the CMHT Manager and Director of Psychology reported that training in psycho-social interventions had increased staff awareness of the need for family based approaches. Psycho-social intervention training awareness is commenced at Trust induction. With other levels of skills-based training programmes being made available. Family based approaches are also incorporated into the work of Crisis and Early Intervention in Psychosis teams
- The Trust's ICPA procedure has undergone a number of revisions since 2007. The 2009 version clearly outlined the need for clinical formulations to be developed by multi-disciplinary teams and the current version (2010) includes reference to thorough review of diagnosis and formulation when responsibility is transferred from between care coordinators
- The ICPA policy includes procedures covering:
    - The role, responsibilities and key competencies for all practitioners, including care coordinators and team managers
    - Transfer and discontinuation of the care coordinator role.

- The Trust has an electronic Mental Health Information System (MHIS) which stores basic patient information details. The need for a single health care record has been re-affirmed by the Trust. The Trust is committed to the implementation of a comprehensive electronic patient record system (RiO) which has an agreed implementation plan commencing late 2010. Full implementation includes the principle that use of paper forms be avoided wherever possible
- The capacity issues associated with the very small size of the Ridgeway Downs CMHT has been resolved with the reconfiguration of CMHTs
- The Trust has implemented a core risk assessment: at interview clinicians commented on its benefit in terms of assessing core risks. It is however worthy of note that the CMHT Manager and Head of Risk both commented on the fact that in their opinion the clinical risk management process was 'not yet well established' and was 'very much in the early stages'
- The monitoring of staff appraisals is now on the Trust's balanced scorecard. In addition to which it was reported that clinical supervision compliance was now being monitored through a mechanism by which managers were required to collate and submit activity returns
- It was reported that the Trust's balanced score card also monitors ICPA practice indicators, e.g. Carer Strategy Completion
- The Trust lost its NHS Litigation Level 1 standard in 2006. However, in 2008 the Trust was successful in obtaining accreditation NHS LA Mental Health/Learning Disability standards Level 1. A requirement of this compliance is that it can demonstrate that it has developed a Training Needs Analysis for its employees by Occupation/Grade. This in practice means that a post holder such as a care coordinator would have their training needs mapped out on the relevant training matrix
- Managers interviewed by the independent investigation team reported that mandatory staff training is now captured electronically via the Managed Learning Environment (MLE). This system enables managers to produce information reports on staff's attendance at training
- In 2008 a specialist skills workshop on OCD was delivered by the Trust (facilitated by an external consultant). This one day workshop was attended by eighty practitioners and received extremely positive evaluations
- The CMHT Manager reported to the independent investigation team that all staff now access Vulnerable Adults awareness training as part of their induction and that it was the responsibility of the respective line manager to ensure the member of staff attended this mandatory training. He also commented that managers are now a position to monitor staff attendance at training via the Trust's Managed Learning Environment (MLE) electronic information system
- The CMHT Manager stated that there was now a greater awareness of staff's responsibility regarding reporting Safeguarding issues. However he also made the point that the training (facilitated by Social Services) regarding 'Safeguarding Investigation Training' was difficult for practitioners to access due to the insufficient number of occasions on which the training was made available.

9 To consider if any omissions or issues identified in the investigation of the incident remain unresolved

9.1 The issue of the Trust ensuring mechanisms within the organisation to meet the requirements of NICE Guidelines regarding OCD (CG31) and Head Injury (CG56) have already been acknowledged previously within the report. Suffice to say that both these requirements remain at the time of the report inadequately addressed.

9.2 The Trust's internal investigation provided a competent report and an appropriate set of proposed recommendations. The report's findings were supported by the use of appropriate root cause analysis tools. The report's structure was in accordance with the Trust's procedure for undertaking a root cause analysis investigation (Serious Adverse Incident Policy and Procedure, 2006, Appendix G).

9.3 The independent investigation team would make the following comments on the report:

- The document does not have any Terms of Reference or scope. At interview one of the report authors commented that he assumed there would have been Terms of Reference agreed at the time but was unable to confirm this. It was reported that Terms of Reference and scope were now incorporated into subsequent serious untoward incident investigation reports
- The serious untoward incident took place on 14 May 2007. However the internal investigation report is dated 08 October 2007. The report recommendations were also 'provisional', being subject to approval by the Integrated Governance Committee and Trust Board. The reason for the time delay was not made clear to the investigation team, however it was reported that such reporting 'is more tightly performance managed'. The independent investigation team were informed that this is now 90 days
- The internal investigation report, although identifying a number of system failures, is silent on the issue of staff accountability. No issues of poorly performing or possible negligence issues (or otherwise) were commented on. The independent investigation team were informed that with hindsight it would have been appropriate to address the issue. The issue of staff accountability should be commented on in a serious untoward incident investigation. The National Patient Safety Agency (NPSA) – Root Cause Analysis 'incident decision tree' may have been of assistance to the internal investigation team in distinguishing if there were any 'staff accountability' issues in addition to 'system failures'
- There was an assumption made that the system failures identified were specific to this individual CMHT. There is no recommendation proposed to seek assurances that the practice failures identified with this case were not also occurring within other CMHTs. It would have been prudent for the organisation to have sought assurances that these failings were unique to this particular CMHT
- The issue of key Trust policies which were in situ at the time of the incident – e.g. ICPA, Clinical Supervision, Records Management, Risk Management etc. - were not reviewed in

terms of the CMHT's failure to follow these or subsequent actions that may have been required to minimise any non-compliance issues. It would seem prudent to have considered an audit of these procedures at the time of the internal investigation report

- The findings from the serious untoward incident (as identified by the Trust's own internal investigation) raise the issue of clinical and organisational risks. In particular it would seem prudent for the Trust to ensure that the responsible SBUs have considered the potential risks of e.g.:
  - The failure to comply with NICE Guidelines
  - The failure to adequately undertake adequate clinical risk assessments
  - The failure to provide adequate clinical supervision
  - The failure to adequately discharge the Trust's Safeguarding and national 'No Secrets' requirements
  - The failure to adequately maintain health care records in accordance with the Trust's own practice standards
  - It would seem prudent for the respective SBUs to ensure that these risks have been adequately considered, in terms of 'risk weighting' against the risks
- It is noteworthy that the internal investigation team did not seek to involve or interview representatives from the day service. Whilst Mr B had been discharged from the service (28 April 2006) he had spent two days per week at the service since 26 November 2004. It would seem appropriate to have obtained the service's perspectives on the incident and to ensure that any lessons learned from joint working practices at the time were shared
- At interview with Mrs A she reported that she had been interviewed as part of the serious untoward incident investigation. However, when asked if any-one had informed her of the findings and outcomes from the investigation she stated that she was unaware of any conclusions or outcomes. Mrs A commented that she would very much like to hear the findings of the investigation. As part of the NPSA 'Being Open' best practice guidance it is recommended that relatives of victims and perpetrators should be provided with an appropriate feedback debrief
- The independent investigation team (at time of reporting) were unable to confirm if 'letters of regret' had been sent out to relatives at the time of the incident
- With reference to the process of disseminating the organisational learning arising from this serious untoward incident, Dr F reported to the independent investigation team that a presentation of the findings of this report had been delivered to approximately fifty senior clinicians. In addition, Dr F stated that he had prepared a report on the characteristics of the Trust's homicides. When asked by the independent investigation team about the dissemination of lessons learned to wider staff groups and other partners/stakeholders it was reported that the organisation had not done enough to ensure that the lessons from the homicides were fully disseminated to all clinical and non-clinical staff. One way that this could be achieved would be by publishing a digest/summary of the key learning points from the homicides which have occurred in the Trust. The opportunity remains to invest in sharing the organisational learning with practitioners, partners, service users and carers.

The opportunity for others to identify ‘latent conditions’ (i.e. practices that can develop over time and lie dormant before combining with other factors to breach a systems safety defences) within their area of work affords them the opportunity to recognise, review, mitigate or remove these problems before they cause an adverse event.

Appendices

Appendix One: Documents reviewed

Table 1: Documents received from Avon and Wiltshire Mental Health Partnership Trust.

Root Cause Analysis Report: Alleged Homicide of Mr A by Mr B on 14th May 2007
The Recognition, Prevention And Management Of Violence And Aggression: 27th February 2006
Policy for the Recognition, Prevention and Management of Violence and Aggression: 17 December 2008 (current)
2nd Cut Assurance Framework (current (8 March 2010), not approved by Board yet)
3rd Cut Assurance Framework (2007/08)
Final Cut Assurance Framework Year End (2010)
Learning & Development Plan, & Calendar of Training Events: April 2009 to March 2010
Learning & Development Plan, & Calendar of Training Events: April 2010 to March 2011
Serious Adverse Incident Policy and Procedure: 24 February 2006
The Policy for the Reporting, Management and Investigation of Adverse Incidents (including Serious Untoward Incidents): 31 July 2009
Policy Index: 2007
Policy Index: current
Policy for Clinical Information, March 2008
Health and Social Care Records Management Policy for Paper Records, v 1.2, 10-10-2006
Health and Social Care Records Management Policy for Paper Records, v. 2.0, 31-03-2008
Health and Social Care Records Management Policy for Paper Records, v 3.0, 25-02-2009
Policy and Procedure for Clinical Supervision, February 2006 revision.
Policy for Handling Praise and Complaints October 2001
Procedure for Handling Complaints October 2001
Being Open Policy, 17 May 2010
A Review of the Incidence, Distribution and Characteristics of Homicides in Avon and Wiltshire Mental Health Partnership Trust: Benchmarked against the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, April 2001

to September 2007 (January 2008)
Physiotherapy Supervision Re-Audit report (June 2007)
Clinical Audit Report: Follow up after 'Did Not Attend' (DNA) (2008)
Clinical Audit Report: Integrated Care Programme Approach Case Notes Re-Audit 2007 (February 2008)
Clinical Audit Report: 2 Audits of Inpatient ICPA from Recommendation made by the MN Inquiry (January 2008)
Clinical Audit Report: Provision of Clinical Supervision within Adult Strategic Business Unit (May 2009)
Clinical Audit Report: Brief ICPA Re-Audit (November 2007)
Are Integrated Care Programme Approach Meetings in the North Bristol Rehabilitation Team, Socially Inclusive and Meeting Good Practice Guidelines from the Clients' Perspective? (November 2007)
Enhanced Unexpected Deaths and Homicide Management Report – Template
Clinical Audit Report: Implementation of NICE Guidelines in the Treatment of Adults with Obsessive-Compulsive Disorder (March 2010)
Secure Services: Part 3 – Supervision Delivery Plan and Progress Report, 2007/08
Current List of proposed clinical audits/EoC reviews from SBUs July 2007.
Clinical Supervision Audit, Secure Services, Wickham Unit, March 2008
Clinical Audit Report: Arts Psychotherapies ICPA report (April 2007)
Clinical Audit Report: An audit of SART II enhanced care plans: how well is education, employment and training considered and documented? (March 2008)
Clinical Records (Mr B , - 3 Volumes, March 1993 to April 2007)
Policy and Procedures for safeguarding vulnerable adults in Swindon and Wiltshire. (September 2006 – minor updates listed, most recent: November 2007)
Trust Policy to Safeguard Vulnerable Adults (November 2008)
Policy and Procedure for Handling Complaints (September 2008)
Policy to Manage Care Pathways and Risk (December 2008)
Policy for the Development and Management of Procedural Documents (January 2010)
NICE Guidance Implementation Policy (November 2008)
Example risk register for Adult SBU 2007/08

Homicide Action Plan (September 2009)
Risk Register, 2010
Care Quality Commission: Avon And Wiltshire Mental Health Partnership NHS Trust Quality and Risk Profile. © Care Quality Commission 2010
Care Programme Approach and Risk Policy (2010)
CPA Care Delivery Procedure (2010)
CPA – Risk Management Procedure (2010)
CPA Meeting Procedure (2010)
Care Programme Approach – Role and key competencies of care coordination procedure (2010).
CPA Dual Diagnosis Procedure (2010)
Report for the Mental Health Review Tribunal on Mr B 12.10.09. Staff Grade Psychiatrist.
Psychiatric Court Report Mr B 05.11.07 Consultant Forensic Psychiatrist
Good Practice Guidance for Staff on the Care and Treatment of People with Comorbid Traumatic Brain Injury and Mental Disorder (Draft) AWP Trust Effectiveness Forum 2008.

Table 2: Documents received from other organisations.

Case Records – Voluntary Organisation, Swindon
Police case file documents.
GP Correspondence

Appendix Two: National guidance reviewed

Department of Health (2005) N*ational Service Framework for Long Term Conditions*
Department of Health (June 2007) *Best Practice in Managing Risk - Principles and evidence for best practice in the assessment and management of risk to self and others in mental health services*
National Patient Safety Agency (2004) *Root Case Analysis Online Toolkit* www.nrls.npsa.nhs.uk/resources/?entryid45=59901
National Patient Safety Agency (2008) *Independent investigation of serious patient safety incidents in mental health services: Good Practice Guidance*
NICE Clinical Guidance 31 (November 2005) *Obsessive Compulsive Disorder: Core interventions in the treatment of obsessive compulsive disorder and body dysmorphic disorder*
NICE Clinical Guidance 56 (September 2007) *Head Injury: Triage, assessment, investigation and early management of head injury in infants, children and adults*
Royal College of Psychiatrists (June 2008) *Rethinking Risk to Others in Mental Health Services*

Appendix Three: The Independent Investigation Team

Mr John Smith ((RMN, RNMH, MBA, BA (Hons), Dip. N, Cert Ed. RNT): Independent Nurse Consultant, Caring Solutions UK Ltd, Lead Investigator

Dr Michael Rosenberg (MB,BS,FRCPsych): Independent Psychiatric Consultant, Caring Solutions UK Ltd,

Dr Colin Dale (PhD, MA, RN, Dip N (Lond), Cert Ed, RNT, DMS): Chief Executive, Caring Solutions UK Ltd

Ms Maggie Clifton (BA, MA, MCMI): Investigations Manager, Caring Solutions UK Ltd

All members of the investigation team are independent of any of the organisations involved with the incident in Avon and Wiltshire and have had no involvement in any of previous investigations into this homicide.

Appendix Four: Abbreviations

AWP	Avon and Wiltshire Mental Health Partnership Trust
BDD	Body Dysmorphic Disorder
CPA	Care Programme Approach
CMHT	Community Mental Health Team
ICPA	Integrated Care Programme Approach
NICE	National Institute for Health and Clinical Excellence
NPSA	National Patient Safety Agency
OCD	Obsessive Compulsive Disorder
PDG	Practice Directives and Guidance
SBU	Strategic Business Unit
w.t.e.	Whole time equivalent

Appendix Five: Anonymisation Index

Anonymisation	Position
Mr A	Victim/stepfather of perpetrator
Mrs A	Widow of victim, mother of perpetrator
Mr B	Perpetrator/stepson of victim
Mrs C	Care Coordinator (1)
Mrs D	Care Coordinator (2)
Dr E	Consultant Psychiatrist
Dr F	Director of Psychology/Member of internal investigation panel
Mr G	CMHT Manager
Dr H	Staff Grade Psychiatrist
Dr I	Neuro-psychologist
Mr H	Author of initial management review
day service	Specialist Voluntary Sector Day Care Service
local mental health charity	Voluntary organisation
employment service	Employment Support Service