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HEALTH & SOCIAL CARE CONSULTING

An independent investigation into the care and treatment of a mental health service user Mr J in Kent

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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Contents

1 Executive Summary

Incident

1.1 Mr J had been under the care of the Early Intervention in Psychosis team in Kent at the time of the attack on his neighbours. He had received treatment in the community and as an inpatient, and he had been inconsistent in his reports of compliance with his medication.

1.2 On 29 September 2018 Mr J knocked on the door of his neighbour's home, Mr and Mrs H, and attacked them and their daughter with a knife. Mrs H and Miss H died of their injuries and Mr H was seriously wounded. Mr H was able to alert emergency services at the beginning of the attack.

1.3 Mr J returned to his home and when the police arrived to arrest him, he surrendered. He was later charged with two counts of murder and one count of attempted murder.

Mental health history

1.4 Mr J had been under the care of the Early Intervention in Psychosis Service since April 2017. He had been allocated a care coordinator and was seen regularly for his medication to be reviewed. He was initially treated with oral aripiprazole.

1.5 In June 2017 Mr J's mental state declined significantly, he was detained on Section 2 Mental Health Act and admitted to an acute mental health inpatient unit. During his inpatient stay his medication was changed from oral aripiprazole to monthly aripiprazole depot injection. The view of the inpatient team was that Mr J was suffering from a psychosis that was possibly drug induced. Mr J admitted to having previously used significant amounts of cannabis.

1.6 On discharge from inpatient services in July 2017 he was initially seen by both the Early Intervention in Psychosis Service and the Crisis Resolution and Home Treatment Team so that assertive follow up care could be provided.

1.7 Mr J frequently complained about receiving his medication via depot injection and made numerous requests to return to oral medication.

1.8 It was reported that his mental health improved notably during the Christmas/New Year period 2017/2018 and in January 2018 his care coordinator supported his request to return to oral medication.

1.9 Concerns started to be expressed by Mr J's mother about his mental state in May 2018 when she reported that he had been using cannabis again and that he had not been taking his medication.

1.10 Mr J was last seen for a face-to-face assessment on 16 July 2018 when his care coordinator documented concerns about his presentation being similar to when he had previously been unwell. He was irritable, agitated and guarded.

1.11 On 10 September 2018 Mr J's mother contacted his care coordinator to express concerns that Mr J was worried he would get into trouble for eating too much and that his hair was falling out. His care coordinator attempted to meet with him the following day, but he stated he was not available. Mr J's care coordinator spoke to him on the phone on 13 September when she documented that he reported that he was eating well and that he was engaged in conversation.

1.12 There was no further contact with Mr J until after the incident.

Independent investigation

1.13 NHS England (South) commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into Mr J's care and treatment. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.14 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

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

1.16 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.17 We would like to express our condolences to all the parties affected by this incident. It is our sincere wish that this report does not add to their pain and distress, and that it goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr J.

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

[2] Department of Health Guidance ECHR Article 2: investigations into mental health incidents https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

Internal investigation

1.18 The Trust undertook a serious incident investigation following the assault on and death of Mr J's neighbours. The investigation was undertaken by a panel comprising a non-executive director, serious incidents and complaints lead, consultant clinical psychologist and an external consultant psychiatrist with expertise in early intervention services.

1.19 The internal investigation found that Mr J's mental illness was insufficiently treated and that it was possible that he had been deteriorating over several months. He did not receive a sufficiently clear and structured service from the Early Intervention in Psychosis Service and there were two key points in time that if managed differently, may have had an impact on the outcome:

- January 2018 when the decision was taken to change Mr J's medication from depot (injection) to oral; and
- during July to September 2018 when there was some evidence that Mr J's mental state may have been deteriorating.

1.20 The internal investigation found that the deaths of Mr J's neighbours was not predictable, but that there was some evidence that they may have been preventable.

1.21 Six recommendations were made:

R1 All Early Intervention in Psychosis staff to be able to undertake a robust mental state examination include using the Positive and Negative Syndrome Scale (PANSS) and be able to develop a relapse prevention plan for each client on their caseload.

R2 All Early Intervention in Psychosis staff to be aware of and actively implement procedures outlined in the Early Intervention in Psychosis Operational Policy following its launch in March 2019.

R3 The Early Intervention in Psychosis Operational Policy needs to contain clear guidance for managing difficult to engage/non-engaging service users, including clarity regarding clients that are being managed at arm's length, including frequency of face-to-face contact.

R4 The Early Intervention in Psychosis team to monitor the risk status and management plans of those individuals whose mental state appears to be deteriorating via a Red Board meeting three times per week. Clarity needed regarding the RAG [red/amber/green] ratings, criteria for each category and what to do and when to do it.

R5 To ensure that all carers are actively involved in Early Intervention in Psychosis throughout the three years the service user is cared for by the service.

R6 For there to be dedicated and consistent medical cover available in all areas that Early Intervention in Psychosis provide a service.

1.22 The Trust developed an action plan to respond to these recommendations and have provided us with a range of documents to evidence implementation.

Forensic history

1.23 Mr J did not have a significant forensic history prior to the attack on his neighbours. Trust records show four previous offences:

- 1 June 2006, common assault for which he received a reprimand.
- 15 February 2007, assault/ABH for which he received a three-month referral order.
- 14 February 2009, possession of cannabis for which he received six months conditional discharge.
- 16 June 2009, burglary for which he received a caution.

Court outcome

1.24 Mr J denied murder on the grounds of insanity, but this was rejected by the jury who found him guilty of manslaughter by reason of diminished responsibility. Mr J was given an order under Section 37 Mental Health Act[3] that he be detained at a high security hospital, with indefinite restrictions under Section 41 Mental Health Act.[4]

Conclusions

1.25 Predictability[5] is "the quality of being regarded as likely to happen, as behaviour or an event". An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[6]

1.26 It is our view that the Trust could not have predicted that Mr J would attack his neighbours. There were no reports of violent outbursts or threats of violence being made.

[3] Section 37 Mental Health Act allows for a court to decide that instead of a prison sentence, a person should be in hospital for treatment of a serious mental health problem.

[4] Section 41 Mental Health Act is also called a "restriction order" and may last for a fixed period of time or it may be indefinite.

[5] http://dictionary.reference.com/browse/predictability

[6] Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120

1.27 Prevention[7] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction". Therefore, for a homicide to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

1.28 However, Mr J had previously not been compliant with oral medication and had only been on depot medication for six months when it was agreed he could return to oral medication.

1.29 There was no robust plan to continue to monitor Mr J's mental state and Mr J was seen for face-to-face appointments on just six occasions between returning to oral medication on 16 January 2018 and the incident involving his neighbours on 29 September 2018.

1.30 Despite concerns that Mr J's psychosis was drug induced, and exacerbated by the use of cannabis, there was little emphasis on accessing substance misuse services and no evidence of any communication between the community mental health teams and the substance misuse service.

1.31 There were concerns expressed by Mr J's mother about his declining mental state in June, July and September 2018. Despite these concerns being raised there had been no face-to-face contact with Mr J since 16 July 2018.

1.32 The content of the concerns raised by Mr J's mother included:

- Mr J masking his symptoms.
- Mr J storing rainwater in the freezer and underneath his bed.
- Inability to raise her concerns in the presence of Mr J in case she upset him.

1.33 In addition, in July Mr J's care coordinator described him as being irritable, agitated and guarded and documented that his appearance was similar to when he had been unwell previously.

1.34 It is therefore our view that there were clear indicators that Mr J's mental state was declining and that arrangements should have been made for a face-to-face assessment. It is also our view that Mr J's care coordinator would have benefitted from the opportunity to discuss Mr J's case with another member of staff in order to identify the most appropriate way to respond to the concerns that had been raised.

1.35 There was a missed opportunity for staff to intervene in the decline of Mr J's mental health in the period August to September 2018, when a robust face-to-face assessment should have been conducted. It is not possible for us to say what the outcome of that assessment would have been. However, it is

[7] http://www.thefreedictionary.com/prevent

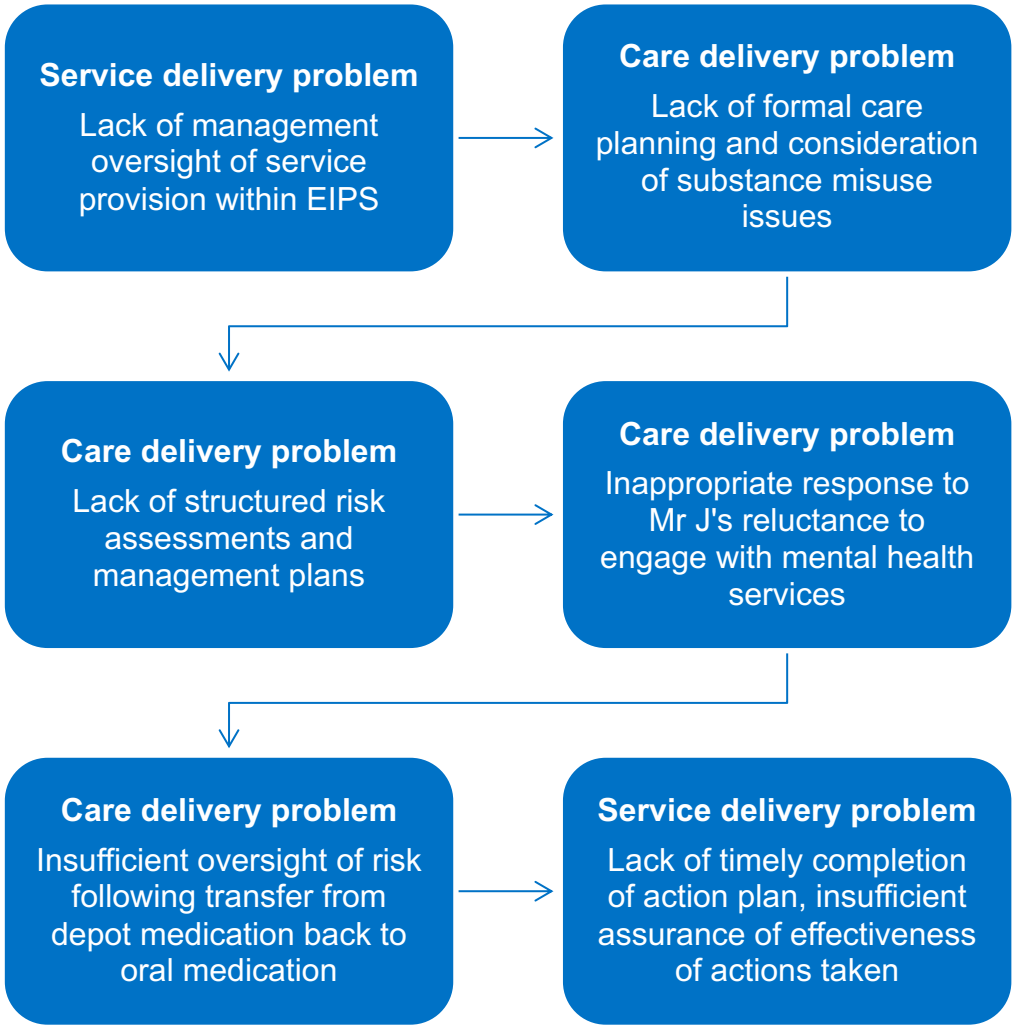
possible that staff may have offered an inpatient admission in order to monitor Mr J's compliance with medication.

1.36 If at that point Mr J had refused to cooperate, it is possible that a Mental Health Act assessment may have been conducted. Again, it is not possible for us to state what the outcome of a Mental Health Act assessment might have been at that point.

1.37 Therefore, we cannot say with certainty that a more robust approach would have prevented the deaths and serious injury to Mr J's neighbours, but it would have reduced the likelihood of this happening.

1.38 Our findings are broadly similar to those from the internal investigation. We have set out in Figure 1 below the care and service delivery problems associated with the care and treatment of Mr J.

Figure 1: Care and service delivery problems associated with Mr J's care and treatment



Recommendations

1.39 This independent investigation has made five recommendations to improve commissioning and clinical practice.

Recommendation 1: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Recommendation 2: The Trust must provide assurance to their commissioners that appropriate, timely and effective action is being taken to complete and embed the learning from the outstanding recommendations in their internal investigation relating to this case.

Recommendation 3: The Trust must provide assurance to their commissioners and the Board that within the Early Intervention in Psychosis Service risk assessments and risk management plans are completed, reviewed, updated and documented in accordance with organisational policy.

Recommendation 4: The Trust must ensure that where appropriate, the Dual Diagnosis Policy is understood and actively implemented by clinical staff.

Recommendation 5: The Trust must provide assurance to the Board and its commissioners that formal operational procedures exist for all services and that those procedures have been reviewed within the appropriate timeframe in accordance with the Trust's own Policy on the management of policies.

2 Independent investigation

Incident

2.1 Mr J had been under the care of the Early Intervention in Psychosis team in Kent at the time of the attack on his neighbours. He had received treatment in the community and as an inpatient and was inconsistent in his reports of compliance with his medication.

2.2 On 29 September 2018 Mr J knocked on the door of his neighbour's home, Mr and Mrs H, and attacked them and their daughter with a knife. Mrs H and Miss H died of their injuries and Mr H was seriously wounded. Mr H was able to alert emergency services at the beginning of the attack.

2.3 Mr J returned to his home and when the police arrived to arrest him, he surrendered. He was later charged with two counts of murder and one count of attempted murder.

Approach to the investigation

2.4 The independent investigation follows the NHS England Serious Incident Framework[8] (March 2015) and Department of Health guidance[9] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

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

2.6 The investigation was carried out by:

- Naomi Ibbs, Senior Consultant for Niche (lead author).
- Dr Mark Potter, Consultant Psychiatrist.

2.7 The investigation team will be referred to in the first-person plural in the report.

2.8 The report was peer reviewed by Nick Moor, Partner at Niche.

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

[9] Department of Health Guidance ECHR Article 2: investigations into mental health incidents. https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

2.9 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[10]

2.10 NHS England sought consent from Mr J for us to have access to relevant clinical records. Mr J consented but did not respond to NHS England to the offer of a meeting with us. NHS England liaised with Mr J's consultant psychiatrist and arrangements were later made to meet with Mr J.

2.11 We used information provided by the following organisations to complete this investigation:

- Kent and Medway Partnership NHS Foundation Trust (the Trust hereafter).
- Mr J's GP surgery.
- NHS Kent and Medway Clinical Commissioning Group.

2.12 As part of our investigation, we interviewed:

- Serious Incidents and Complaints Investigation Lead.
- Operational Patient Safety and Risk Manager.
- Lead investigator for internal investigation.
- Consultant Clinical Psychologist (providing clinical advice to the internal investigation).
- Consultant Psychiatrist.
- Care Coordinator.

2.13 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview.

2.14 We also undertook a telephone discussion (which was not recorded or transcribed) with the Deputy Chief Nurse for NHS Kent and Medway CCG.

2.15 A full list of all documents we referenced is in Appendix B, and an anonymised list of all professionals is in Appendix C.

2.16 The draft report was shared with:

- NHS England.
- The Trust.

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

- Mr J's GP surgery.
- NHS Kent and Medway Clinical Commissioning Group.

2.17 This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with Mr J and his family

2.18 We and NHS England met with Mr J at the secure hospital where he is receiving treatment. We explained the purpose of our investigation and invited Mr J to give us any information he believed would be relevant. Mr J was wary of us and did not share any information with us.

2.19 We and NHS England met with Mr J's mother (Mrs J) separately. Mrs J told us that Mr J had become very unwell in 2017 and that prior to being admitted to hospital would only drink rainwater collected in plastic bottles and eat rice or porridge. Mrs J also told us that Mr J would test his food on the family pet fish to see if it was safe to eat.

2.20 Mrs J said that their family would use distraction techniques to be able to check Mr J's room to see if he had taken his medication. This was not always successful.

2.21 Mrs J often worked away from home and travelled to other countries for this purpose. Mrs J told us that Mr J was not happy about her leaving the family home and that he was worried about her safety. On three occasions Mr J told Mrs J that he was going to kill her and his brother and sister. Mr J told his mother that the voices were telling him that he had to kill her to save her and that he was fighting them not to do so.

2.22 Mrs J told us that she believes that Mr J does not have a needle phobia (as he has often reported to clinical staff). She believes that Mr J does not want to have his blood taken because he thinks that something will happen with it.

2.23 Mr J's brother had moved to another country, a great distance from the UK, shortly prior to the attack on their neighbours. Mrs J told us that Mr J loved his brother very much and that she believes this event was a trigger for Mr J's relapse.

2.24 Mrs J told us that following the attack she was subjected to hate mail, attacks on her property, and sent rape and death threats. Mrs J also told us that she felt unable to continue to live next door to the surviving neighbour. As a result of this Mrs J felt she had to leave the family home and she has not felt able to return.

2.25 We offered to meet with Mr J and Mrs J again at the end of the investigation. We met with Mrs J to provide feedback on the report and answer her questions. She informed us that Mr J's mental health was unstable and

therefore NHSE will approach Mr J's care team in due course before sharing the report with him.

2.26 NHSE contacted Mr J's father at the beginning of the investigation but did not receive a response. Further contact was made prior to the report being finalised and published. [Update when suitable time has passed held].

Contact with Mr H

2.27 We have not had any contact with Mr H. NHS England contacted Mr H at the start of the investigation. Through his daughter-in-law, Mr H advised that he did not wish to have any direct contact with us at that time. NHS England has continued to provide updates to Mr H via his daughter-in-law during the process of the investigation.

2.28 We remained committed to meeting or speaking with Mr H and/or his family prior to publication of the report, should they wish to do so.

Structure of the report

2.29 Section 3 sets out the details of the care and treatment provided to Mr J with detailed information provided at Appendix D. We have provided an anonymised summary of those staff involved in Mr J's care and treatment for ease of reference for the reader. These can be found at Appendix C.

2.30 Section 4 examines the communication the Trust had with affected families after the death of Mr J's neighbours.

2.31 Section 5 provides a review of the internal investigation and reports on progress made in addressing the organisational and operational matters identified.

2.32 Section 6 examines the issues arising from the care and treatment provided to Mr J and includes comment and analysis.

2.33 Section 7 sets out our overall conclusions and recommendations.

3 Summary of Mr J's care and treatment

3.1 This section provides a brief overview of Mr J's relevant mental health history and a summary of relevant events between from July 2017 to September 2018. We have provided a detailed chronology of Mr J's care and treatment at Appendix D.

Overview of relevant mental health history

2008 to 2009

3.2 In July 2008 Mr J's GP documented that Mr J's mother had persuaded him to attend an appointment. Mr J reported that he had smoked cannabis since the age of 15 years and that he was increasingly dependent upon it to feel "good and relaxed".

3.3 In January 2009 Mr J's GP documented that Mr J reported that his cannabis use was only at weekends, and he was not using anything stronger.

3.4 In June 2009 Mrs J reported to Mr J's GP that she had to exclude him from the family home because of his "bad behaviour". She was unsure where he was living and had seen him recently looking "agitated and ill-kept". Mr J had told Mrs J that he could communicate with the antennae of ants and that he could identify when an earthquake was due to occur. Mr J was paranoid and felt people were watching him, he also reported that his mother was "evil".

3.5 Mr J later forced entry into the family home, causing damage, and denied that he was paranoid. The police were called, and he was arrested. An assessment (it is unclear by whom) in police custody concluded that there were no signs of paranoia or delusions. It is documented that Mrs J was given the telephone number for the Early Intervention in Psychosis service in case Mr J was suffering from a drug-induced psychosis.

2013

3.6 In September 2013 Mr J's GP documented that Mr J presented with symptoms of stress following an incident in the kitchen where Mr J had been working as a chef. Mr J reported that he had been involved in a row with another member of staff who later made threats towards Mr J. Mr J was signed off work with stress from 13 December 2013 until 26 February 2014.

January to July 2017

3.7 In February 2017 Mr J attended an appointment with his GP because he was suffering from chronic anxiety. Mr J reported that although he had used a lot of drugs in the past, he had not used any for more than three years. Mr J reported:

- struggling with low mood and anxiety for one to two years;

- some paranoid ideation;
- visual and auditory hallucinations; and
- suicidal thoughts (electrical equipment in the bath).

3.8 Mr J was referred to the community mental health team and was seen by a consultant psychiatrist who documented that his impression was that Mr J was experiencing psychosis, which given the long duration was likely to be schizophrenia. He was prescribed aripiprazole 10mg.

3.9 Mr J was then accepted onto the caseload of the early intervention and was allocated a care coordinator and a support time and recovery worker.

3.10 In May 2017 concerns were expressed by Mr J's mother and his care coordinator that Mr J may not be taking his medication in accordance with his prescription. Mr J's care coordinator also documented concerns that there had not been more improvement in his mental state.

3.11 Mr J's mental state continued to deteriorate and on 24 June 2017 a Mental Health Act assessment was arranged. Mr J was detained on Section 2 Mental Health Act and admitted to Boughton Ward (a mental health acute inpatient ward) at Priority House Hospital in Maidstone.

3.12 During his admission to hospital Mr J admitted that he had not been compliant with his medication and also admitted to using cannabis. Mr J's medication was changed from oral aripiprazole to depot injection aripiprazole 400mg to be administered monthly. He received his first injection on 5 July 2017 and continued to be administered oral aripiprazole 10mg until his discharge from hospital on 10 July 2017.

10 July 2017 onwards

3.13 When Mr J was discharged from hospital on 10 July 2017, he was provided with nine days' worth of medication (aripiprazole 10mg) and was referred to the Crisis Resolution and Home Treatment Team for post discharge monitoring. The discharge summary documented Mr J's diagnosis as "mental and behavioural disorders due to substance misuse" and stated that Mr J had agreed to seek help from the drug and alcohol service.

3.14 Mr J reported feeling better but the day after discharging his mother expressed concerns to his care coordinator about continued paranoid thinking, and his care coordinator documented that Mr J had appeared guarded and paranoid. However, Crisis Resolution and Home Treatment Team staff documented that Mr J appeared to have "good insight" into his mental illness.

3.15 On 24 July 2017 Mr J was reviewed by a consultant psychiatrist in the community (CP2). CP2 documented Mr J's diagnosis as "psychotic disorder, possibly drug induced". Mr J asked to reduce or stop the aripiprazole or return to oral medication. CP2 documented that a "lengthy discussion" took

place about the need to comply with medication for a sustainable period of time and it was concluded that Mr J would remain on depot aripiprazole.

3.16 Over the following few weeks Mr J's care coordinator (CCO1) and the support time and recovery worker (STR1) documented that Mr J remained anxious. In addition, Mr J did not associate any improvement in his mental state to the medication, which he told STR1 was poison.

3.17 In mid-August Mr J's mother reported to CCO1 that Mr J was low in mood and irritable and that he had stated "I was fine before I went into hospital, nothing was wrong". Mr J considered that the depot injection was making him unwell and asked that the next injection was in his gluteal because the injection in his arm was "too close to his heart". CCO1 documented that both she and Mr J's mother were concerned about Mr J's presentation and that his mental state did not appear to have improved.

3.18 On 18 August 2017 CCO1 and STR1 met with Mr J who presented as pale, complained of fatigue, and spoke of delusional beliefs about his heart and eyes. Mr J again spoke of reducing his medication and asked that CCO1 not be present for the next appointment (on 29 August) with the consultant psychiatrist because she "might add to things". Mr J was guarded and appeared threatened by staff suggestions and observations. Mr J's mother reported that Mr J was isolating himself more, masking his symptoms and lying. Mr J's mother told CCO1 that she believed he was reporting side effects of his medication in order for it to be stopped.

3.19 On 29 August 2017 CCO1 was due to see Mr J but documented that his mother cancelled the appointment because Mr J had two other appointments that week and she (his mother) was concerned that a third appointment would be too much for him to manage. Mr J's mother reported some improvements in his mental state but remained concerned that his kitchen skills were declining notably; he had been unable to operate the oven and had undercooked his sausages, despite previously having worked as a chef.

3.20 On 31 August Mr J attended an appointment with CCO1 and CP2 who documented that Mr J had been presenting with behaviours that were considered to be "significant relapse warning" signs. In a letter from CP2 to Mr J's GP, CP2 documented that there had been a "recent noticeable improvement" and there were no major concerns evident that day. CP2 also documented that Mr J had good insight and that "risks remain very low", the plan was for Mr J to continue with the medication as prescribed and that he had agreed not to have any reduction at that time and that he was happy to continue to work with his care coordinator and the early intervention team.

3.21 A retrospective entry by CCO1 documented that during the appointment with CP2 Mr J had suggested he only had to take his medication for a further two months. Mr J denied that he had previously thought he was being poisoned by cannabis and became agitated because he believed that CCO1 was making up information about him and that she and his mother were not retaining or understanding what he was telling them. It was suggested that Mr J's mother and CCO1 were simply recounting information that Mr J had

forgotten about, but Mr J denied there was anything wrong with his memory. Mr J remained contradictory with his reports throughout the appointment. When Mr J was reminded that he had said that birds and planes were talking to him, he agreed but denied that these were hallucinations. Mr J was concerned about information sharing between his mother and other professionals and therefore it was agreed a meeting would be arranged to ensure that Mr J was aware of what information was being shared.

3.22 On 18 September 2017 CCO1 met with Mr J who was more relaxed and appeared less paranoid and preoccupied. Mr J's mother remained concerned about some of Mr J's behaviours and lack of cognitive ability. CCO1 therefore asked Mr J's GP to conduct a mini-mental state examination (MMSE).[11]

3.23 On 26 September 2017 CCO1 met with Mr J again. Mr J remained unhappy about receiving his medication via injection and said he expected to see a doctor prior to each injection. CCO1 advised he would be seen by a doctor every three to six months. Mr J was keen to stop his medication and became agitated, indicating he did not want to accept the injection and that he wanted oral medication. CCO1 advised about the risks of not accepting the injection and the risks of being admitted to hospital if he did not take his medication. Mr J denied the risks and suggested that CCO1 had exaggerated his symptoms and recorded information incorrectly that had led to his previous admission to hospital. CCO1 provided reassurances and documented that a timeline of events would be developed and a follow up appointment with CP2 would be arranged.

3.24 CCO1 met with Mr J again on 5 October 2017 to administer his injection. Mr J was contradictory in the information he gave to CCO1 during the appointment.

3.25 On 7 November 2017 Mr J refused to attend his appointment at the clinic because he denied an appointment had been arranged. Therefore, CCO1 met Mr J and his mother at home. CCO1 documented that Mr J was declining all interventions with mental health services, with the exception of his aripiprazole injection which he wished to discuss with CP2. Mr J did not consider he had a mental health disorder and felt that he would manage independently without treatment. Mr J's mother remained concerned about his mental health and his cognitive ability and was further concerned that his reluctance to engage with mental health services would result in relapse. Mr J's mother was keen to remain in contact with the early intervention team. Mr J's mother later informed CCO1 that Mr J had met his father who had indicated that Mr J could not be forced to accept his depot injection.

3.26 On 11 December 2017 Mr J again talked with CCO1 about stopping the aripiprazole injection. It was agreed that this would be discussed with CP2 at an appointment in January 2018.

[11] Mini-mental state examination (MMSE) is the most commonly used test for complaints of problems with memory or other mental abilities. It consists of a series of questions and tests, each of which scores points if answered correctly. The MMSE tests a number of different mental abilities, including a person's memory, attention and language.

2018

3.27 On 5 January 2018 CCO1 contacted Mr J's mother who reported a significant improvement during the Christmas period. She also reported that Mr J was nervous about meeting a new consultant psychiatrist and that he remained "desperate to come off" the aripiprazole injection.

3.28 On 16 January 2018 Mr J met with CCO1 and EIPS3 (a student nurse). Mr J appeared well dressed and relaxed and agreed for CCO1 to administer the aripiprazole injection. He again spoke of changing to oral medication. CCO1 later documented that she would support his request to move to oral medication because she felt he would remain compliant.

3.29 On 29 January 2018 Mr J and his mother met with CCO1 and CP3 (the new consultant psychiatrist). CP3 documented that Mr J was doing well and had made good progress. CP3 agreed to prescribe oral aripiprazole 20mg for 14 days and 30mg daily thereafter, he also prescribed clonazepam 0.5mg daily for seven days. CP3 documented Mr J's risks to himself as risk of relapse and risk of self-neglect, and risks to others as "not known".

3.30 CCO1 met with Mr J on 2 February 2018 and documented that there were "no further worries" at that time other than anxiety that Mr J was experiencing.

3.31 On 13 March 2018 CCO1 spoke with Mr J's mother who reported that he was doing well and that he had a girlfriend who was supportive of him.

3.32 CCO1 met with Mr J on 19 March 2018 when she documented that he seemed well, relaxed and that there were no concerns. Mr J reported that he was taking his medication, aripiprazole 30mg, and that he was pleased the aripiprazole injection had been stopped.

3.33 On 24 May 2018 Mr J's mother reported to CCO1 that Mr J had been using cannabis and that she believed he had done so because his girlfriend had also been using cannabis. Mr J's mother had confronted him and told him that if he were to continue to use cannabis he would have to move out, she had also banned his girlfriend from coming to the family home. Mr J's mother expressed concern that he had not been taking his medication or collecting his prescription. CCO1 documented she would contact Mr J's GP and arrange to see Mr J. A later entry indicates that the last prescription was issued on 15 May 2018. (GP records do not confirm or dispute this information).

3.34 CCO1 met with Mr J on 4 June 2018. Mr J advised that he was taking his medication and reported no side effects. CCO1 documented "no concerns or risks raised".

3.35 On 16 July 2018 Mr J's mother contacted CCO1 to express concern about his presentation, he was "edgy, irritable and guarded". Mr J had lost his job at a supermarket but had not been able to ascertain why. He had since got another job as a labourer. Mr J's mother said that he had been telling members of the family different information about himself. CCO1 visited Mr J

and documented that he had become irritable and agitated with her and that he had dark circles under his eyes, an indication of possible relapse. Mr J did not appear distressed by the loss of his supermarket job.

3.36 During a text conversation on 22 August 2018 to arrange a further appointment Mr J reported to CCO1 that he had changed jobs again after a previous job had ended quickly and his new job was due to start the following week.

3.37 On 5 September 2018 CCO1 spoke to Mr J whilst he was at work (as a labourer). Mr J expected that job to last until November at which time he planned to seek a job indoors. Mr J reported feeling well and had no concerns about his mood, diet or anxiety. He said that he was compliant with his medication and declined talking therapy. He felt he no longer needed support from the early intervention team but agreed to an appointment with the consultant psychiatrist in October.

3.38 On 10 September 2018 Mr J's mother contacted CCO1 to express concerns about Mr J who had asked if he would get into trouble for eating too much. Mr J had also reported suffering a migraine and concerns about his hair falling out. CCO1 documented she planned to meet Mr J the following day but he had said he was not available so it was agreed a telephone call would take place.

3.39 Mr J spoke to CCO1 on the telephone on 13 September 2018 and reported no concerns.

3.40 On 29 September 2018 Mr J was arrested after he had attacked and injured Mr H, and fatally injured Mr H's wife and daughter.

4 Duty of Candour

4.1 We have reviewed the Trust's recording of its actions under the Care Quality Commission Regulation 20: Duty of Candour. Regulation 20 was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. In interpreting the regulation on the Duty of Candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- **"Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.
- **Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.
- **Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."

4.2 To meet the requirements of Regulation 20, a registered provider has to:

- "Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.
- Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred and provide support to them in relation to the incident, including when giving the notification.
- Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.
- Advise the relevant person what further enquiries the provider believes are appropriate.
- Offer an apology.
- Follow up the apology by giving the same information in writing and providing an update on the enquiries.
- Keep a written record of all communication with the relevant person."

4.3 We have included the full excerpt of the regulations at Appendix E.

4.4 The regulations are clear that the "relevant person" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

4.5 In this case therefore, Mr J was the "relevant person".

4.6 The Trust Duty of Candour policy in place at the time stated that the Trust must notify the patient within ten working days of the incident being known, that an incident had occurred. The policy also stated that where the patient was not well enough, there must be a record to reflect that fact.

4.7 The Trust has stated that the lead investigator advised that Mr J "was deemed to be too unwell to receive the Duty of Candour". We have seen no evidence that the Trust attempted to contact Mr J, nor any record made at the time that he was not well enough to be contacted.

4.8 We have previously made a recommendation to NHS England to produce clear guidance for organisations regarding Duty of Candour when there is an incident that is also the subject of a serious criminal investigation. Therefore, we have not made a further recommendation here.

4.9 The Trust's approach to engaging families affected by homicide and serious incidents is described in their Duty of Candour Policy. The version in use at the time of the death of Mr H's family states that where a patient has died their family/carer must be similarly cared for and involved, and that consideration must be given to their needs first. This provided a framework for the Trust to have involved Mr J's family in the investigation following the death of Mr H's family, but does not reference how the Trust should have involved Mr H. The current policy makes no reference to this either.

4.10 We acknowledge that despite the absence of policy guidance, the Trust Chief Executive made attempts to contact Mr H via Kent Police. We discuss this further on page 20.

4.11 NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide[12]. This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation". The Trust should review this publication and ensure that its own policy reflects the actions taken by Chief Executive at the time and the best practice referenced.

Recommendation 1: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

[12] https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

Communication with Mr J's parents – Being Open

4.12 Mr J's parents are separated, and the Trust communicated with them separately. We have seen that the Trust Chief Executive wrote to Mr J's parents in early April 2019 to provide their contact details and to offer to meet with them.

4.13 Mr J's parents both received copies of the completed internal investigation report, along with the offer of a face-to-face meeting.

4.14 Correspondence sent to Mr J's mother in June 2019 followed a meeting with the Chief Executive. During the meeting Mr J's mother identified that information came to light during the court case that contradicted what had been written in the progress notes at the time of Mr J's assessment by the Criminal Justice and Liaison Diversion Service. The Chief Executive advised that the learning was shared with clinicians via the Trust wide learning bulletin and that staff would be advised to add to the progress note "that this may not be a reliable / is not a collaborated account" when it applies.

Communication with Mr H's family – Being Open

4.15 It is our understanding that Mr H, his wife and daughter were not patients of the Trust. Therefore, Duty of Candour did not apply to them. However, it is good practice and in the spirit of 'Being Open' for the Trust to have made contact with Mr H.

4.16 In early November 2018 the Trust contacted Kent Police to ask that one of their officers offer Mr H the opportunity to meet with the Trust and for him to be involved in the internal investigation if he wished. Kent Police confirmed later in November 2018 that Mr H did not wish to meet with the Trust. Kent Police also advised that they update Mr H with the outcome of any meetings when appropriate.

4.17 The Trust Chief Executive wrote to Mr H on 18 December 2018. The letter was sensitive and well written, acknowledging that Mr H may wish to have no contact with the Trust. There appears to have been no response from Mr H and no further communication with him by the Trust, which we consider was appropriate.

5 Internal investigation

5.1 The terms of reference for this independent investigation require us to review the internal investigation, in particular the adequacy of its findings, recommendations and implementation of the action plan and identify:

- if the investigations satisfied their own terms of reference;
- if all key issues and lessons have been identified and shared; and
- whether recommendations are appropriate, comprehensive and flow from the lessons learnt.

5.2 We are also required to:

- review progress made against the action plans;
- review processes in place to embed any lessons learnt and any evidence to support positive changes in practice; and
- review the clinical commissioning groups oversight of the resulting action plan.

5.3 We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency,[13] NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths.[14] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

5.4 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA^2 (or Root Cause Analysis and Action, hence 'RCA Squared')[15] which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

5.5 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.

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

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

[15] National Patient Safety Foundation (2016) - RCA2 - Improving Root Cause Analyses and Actions to Prevent Harm – published by Institute of Healthcare Improvement, USA.

- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'.[16]
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete.

5.6 We also considered proposals for the new NHS Improvement Patient Safety Incident Response Framework on how to improve learning from investigations which has identified five key problems with the current application of the process:

- defensive culture/lack of trust, e.g., lack of patient/staff involvement;
- inappropriate use of serious incident process, e.g., doing too many, overly superficial investigations;
- misaligned oversight/assurance process, e.g., too much focus on process related statistics rather than quality;
- lack of time/expertise, e.g., clinicians with little training in investigations trying to do them in spare time; and
- inconsistent use of evidence-based investigation methodology, e.g., too much focus on fact finding, but not enough on analysing why it happened.

5.7 Our detailed review of the internal report is at Appendix F. In summary we have assessed the 25 standards as follows:

- Standards met: 22.
- Standards partially met: 2.
- Standards not met: 1.

[16] Marx, D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University Press, 2001.

5.8 We discuss our analysis below.

Analysis of Provider internal investigation

5.9 The NHS England Serious Incident Framework states that internal investigation should be completed within 60 days. The date of the incident was 29 September 2018, but the internal investigation report is dated 8 March 2019. The report does not provide narrative on the reasons for the delay which is beyond 60 working days. Although this is not uncommon for investigations where there is an associated complex criminal investigation, there is no explanation in the report of requests made to the relevant CCG to request an extension.

5.10 The Trust provided us with evidence of an extension request made to the CCG on 11 October which was approved. The revised date for submission of the report was agreed by the CCG as 27 March 2019. Trust staff confirmed at interview that the CCGs do not support 'stop the clock'[17] requests.

5.11 The terms of reference were agreed with input from Mr J's family and there is a description of what support from Trust staff was provided to them. We consider that the internal investigation satisfied the terms of reference set with the exception of providing specific responses to the family's questions set out on page 6 of the report. We have set out our findings in Table 1 below.

Table 1: Terms of reference for internal investigation

Internal investigation terms of reference		Niche comment
1	Was the care and treatment delivered to the service user, from the time he was accepted into Secondary Care Mental Health Services consistent with the Operational Policies for the Community Mental Health Team and the Early Intervention for Psychosis Service?	The report addressed the degree of compliance and identified that the operational policy "lacked specificity and was out of date". Term of reference satisfied.
2	Examine the role of system delivery issues in the care and treatment delivered.	The report identified a "lack of rigour and focus in the delivery of an Early Intervention in Psychosis service… exacerbated by an insufficiently robust Early Intervention in Psychosis policy". Also identified were a lack of scrutiny of caseloads and lack of clarity around standards of engagement. Term of reference satisfied.
3	Address issues raised by the service user's family:	On page 7 of the report, it states that the questions are addressed

[17] Within the current serious incident system (STEIS) commissioners may 'stop the clock' where there is a formal request to suspend an investigation. The date for completion should be reviewed and agreed again once the investigation can recommence. https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

Internal investigation terms of reference		Niche comment
	a. What was Mr J's diagnosis and why were they not told this? b. Why was Mr J allowed to go back on oral medication? c. Why, when Mr J did not engage with the groups/activities offered, was this not followed up? d. How did the Trust come to the conclusion that Mr J did not pose a risk to others?	in the main body of the report. It would have been helpful to the family for responses to the questions to have been provided in this section, as is the case for the other terms of reference. We are unable to identify that the report provides a response to question 3a. Question 3b is dealt with on pages 12, and 13. The report does not provide a specific response to question 3c, although the issue of engagement more generally is addressed on pages 10 and 11. The report does not provide a specific response to question 3d, the authors conclude on page 3 that there was "no evidence to suggest with the benefit of hindsight" that Mr J posed a risk to others in the two years prior to the incident.
4	How often was the service user seen in September?	The report identifies that Mr J was not seen in September 2018, but his care coordinator spoke to him on the telephone on two occasions. Term of reference satisfied.
5	Should the service user's employer have been told he had a mental illness?	The report states that it is not the responsibility of Trust staff to inform a service user's employer about mental health issues. Service users would be encouraged to disclose the information at the "right time…to the right person in the right environment". Term of reference satisfied.

5.12 The report also describes the support provided to staff following the incident.

5.13 The investigation team identified good practice, missed opportunities, and contributing factors.

5.14 The report considers what factors contributed to poor care and missed opportunities, but these are not directly linked with how a recurrence might be prevented.

5.15 We consider that all key issues and lessons have been identified and shared, but that further evidence is required to demonstrate the effectiveness of the actions taken in response to the recommendations. We discuss this further from paragraph 5.29 below.

5.16 The term root cause in a systems or root cause analysis investigation is identified by the National Patient Safety Agency (England) as:

"The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence."

5.17 We have provided a more in-depth definition of the term 'root cause' at Appendix G.

5.18 The root causes section was completed but it does not identify a single root cause. The root causes section considers predictability and preventability and identifies two key points in time that "if managed differently, may have had an impact on the outcome". The two key points were identified as:

- January 2018 when the decision was made to change Mr J from depot medication to oral medication. The investigation team noted it was probably that others may also have taken this decision, the risks associated with the change did not lead to an appropriately robust level of monitoring in the following months.

- July to September 2018 when there was some evidence that Mr J's mental state may have been deteriorating. The investigation team acknowledged that maintaining engagement with Mr J was challenging but stated that his case should have been discussed at the locality team meeting.

5.19 There were six recommendations made, all of which we consider to have been appropriate and comprehensive. They also flow from the lessons identified:

R1 All Early Intervention for Psychosis (EIP) staff to be able to undertake a robust mental state examination including using the Positive and Negative Syndrome Scale (PANSS) and be able to develop a relapse prevention plan for each client on their caseload.

R2 All EIP staff to be aware of and actively implement procedures outlined in the EIP Operational Policy following its launch in March 2019.

R3 The EIP Operational Policy needs to contain clear guidance for managing difficult to engage / non-engaging service users, including clarity regarding clients that are being managed at arm's length, including frequency of face-to-face contact.

R4 The EIP team to monitor the risk status and management plans of those individuals whose mental state appears to be deteriorating via a

Red Board meeting three times per week. Clarity needed regarding the RAG ratings, criteria for each category and what to do and when to do it.

R5 To ensure that all carers are actively involved in EIP throughout the three years the service user is cared for by the service.

R6 For there to be dedicated and consistent medical cover available in all areas that EIP provide a service.

5.20 The Trust process in place at the time for completing investigation reports was outlined in the Investigation of Serious Incidents, Incidents, Complaints and Claims Policy. This stated that:

- Draft investigation report to be submitted to the Care Group Serious Incident Lead within 45 working days from the incident.
- Draft report to be shared with those involved in the incident, responses related to factual accuracy to be submitted within two weeks.
- Findings to be reviewed by each care group and the Trust Wide Patient Safety and Mortality Group in the case of suspected suicides.
- Final investigation report to be submitted to the relevant CCG within 60 working days.
- Copy of the report to be shared with: patient, family and/or carers; team involved in the incident; Care Group Director of the area involved who will ensure the recommendations are written into an action plan.

Action plan

5.21 The Trust developed an action plan following completion of the investigation report, and this was included in the copy of the investigation report we received. We have seen two versions dated 9 February 2019 and 6 April 2020.

5.22 The action plan dated 9 February 2019 provides a description of the actions for each recommendation and the title of the person responsible for ensuring these are completed. The due date is simply cited as "End Q2" or "End Q3". It is unclear therefore which year the actions are expected to be completed. Whilst this is a minor point, we suggest that the Trust ensures that due dates are clearly set out to avoid ambiguity.

5.23 There is no indication on the version of the action plan dated 9 February 2019 whether actions have been completed and if so, when this was achieved.

5.24 The copy of the action plan dated 6 April 2020 is a version that the Trust had extracted from their incident management system. This includes specific due dates and also completion dates where appropriate. Further detail on the progress of actions was also included.

5.25 We have seen evidence that at the time the Trust monitored overdue actions every week at Serious Incidents Review Panel meetings. Two functions of the Serious Incident Review Panel were:

- "To provide Panel approval to close serious incident actions where evidence is robust.
- To reject and provide guidance to the action owner in order for them to resubmit robust evidence against the action."[18]

5.26 We have seen evidence that further evidence or action is requested to demonstrate that a recommendation has been addressed.

5.27 In addition to the Serious Incident Review Panel the Trust has established a Serious Incident Actions Closure Governance Meeting. This group meets fortnightly, and its purpose is:

- "To undertake a review of completed serious incident actions in order to provide assurance of the quality and degree of completion of serious incident actions.
- For actions completed in relation to serious incidents and Coroner's Preventing Future Death actions…"[19]

5.28 The Trust advised that the new meeting arrangements were subject to an audit, the findings of which were not available at the time the information was shared with us.

Progress of actions

5.29 Assessing the success of learning and improvement can be a very nuanced process. Importantly, the assessment is meant to be useful and evaluative, rather than punitive and judgemental. We adopt a numerical grading system to support the representation of 'progress data'.

We deliberately avoid using traditional RAG ratings, instead preferring to help organisations to focus upon the steps they need to take to move between the stages of completed, embedded, impactful and sustained; with an improvement which has been 'sustained' as the best available outcome and response to the original recommendation. Our measurement criteria are set out in

[18] Community Recovery Care Group Serious Incident Review Panel Terms of Reference October 2018

[19] Acute and Community Recovery Care Groups Operational Patient Safety and Risk Team Serious Incident Actions Closure Governance Meeting Terms of Reference February 2020

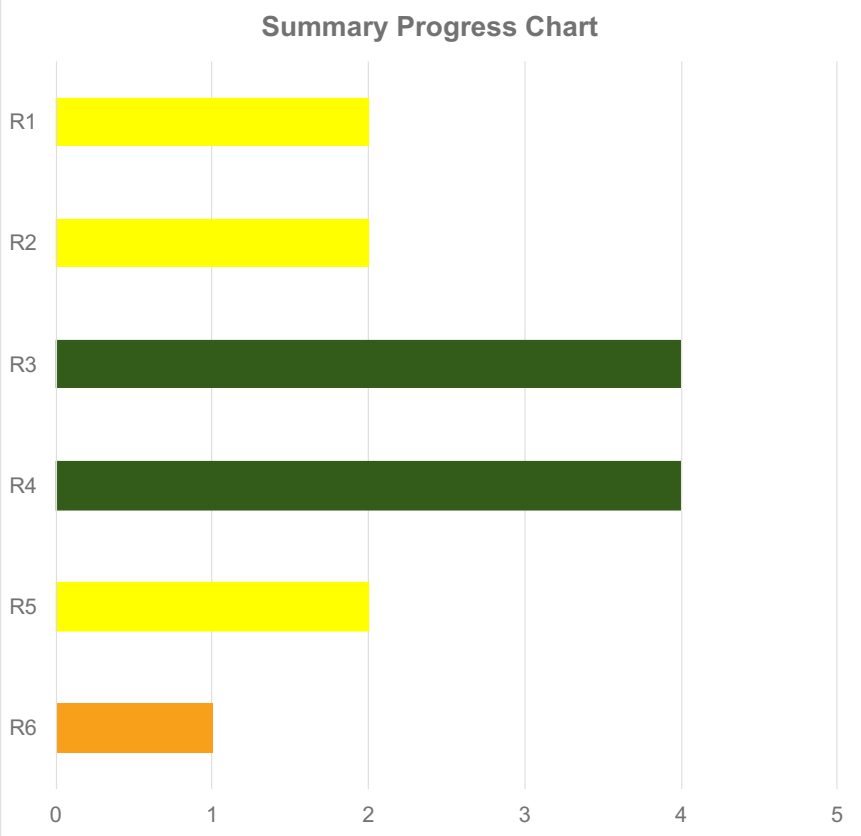
5.30 Table 2 below.

Table 2: Niche Investigation Assurance Framework measurement criteria

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

5.31 The Trust provided evidence of actions for each recommendation. A summary of the Trust narrative on progress, along with our detailed comments can be found in Appendix H. Our assessment of progress of Trust actions is set out in Figure 2 below.

Figure 2: Summary of assessment on progress of action plan



Trust recommendation 1

5.32 A list of care coordinators was provided, indicating whether they had completed the PANSS training. This shows that from a total of 50 care coordinators, 38 (76%) had completed training. We note that one of the 12 care coordinators who had not completed the training was Mr J's care coordinator. It is not clear from the information provided how many of the 12 care coordinators who had not completed the training were new staff.

5.33 An audit completed in October 2019 of PANSS assessments for the East found that only 44% of patients (11) had a PANSS completed, and four of these had been completed more than 13 months prior to the audit. An audit completed in October 2019 of PANSS assessments for the West/North found that only 8% of patients (two) had a PANSS completed, one of which had been completed 15 months prior to the audit.

5.34 The revised Early Intervention in Psychosis operational policy produced in March 2019 states that PANSS should be updated at each Care Programme Approach review, and this should be undertaken every six months for Early Intervention in Psychosis patients. We have not assessed the degree of compliance with the Care Programme Approach policy.

5.35 The action plan documents that this action was closed on 7 February 2020. However, the detailed action plan indicates that this action remains open and therefore we would expect to see further action being taken by the Trust.

5.36 Although the Trust has tested the effectiveness of the action, our analysis shows that not all Early Intervention in Psychosis staff have been trained in PANSS training and the Trust audit found that only 47% of newly referred patients had a PANSS completed.

5.37 In addition, staff were no longer expected to act in accordance with the new policy in completing a PANSS assessment every six months, prior to a patient's Care Programme Approach review.

5.38 The Trust advised in March 2021 that a new policy had been implemented that stated that PANSS should be undertaken at initial assessment.

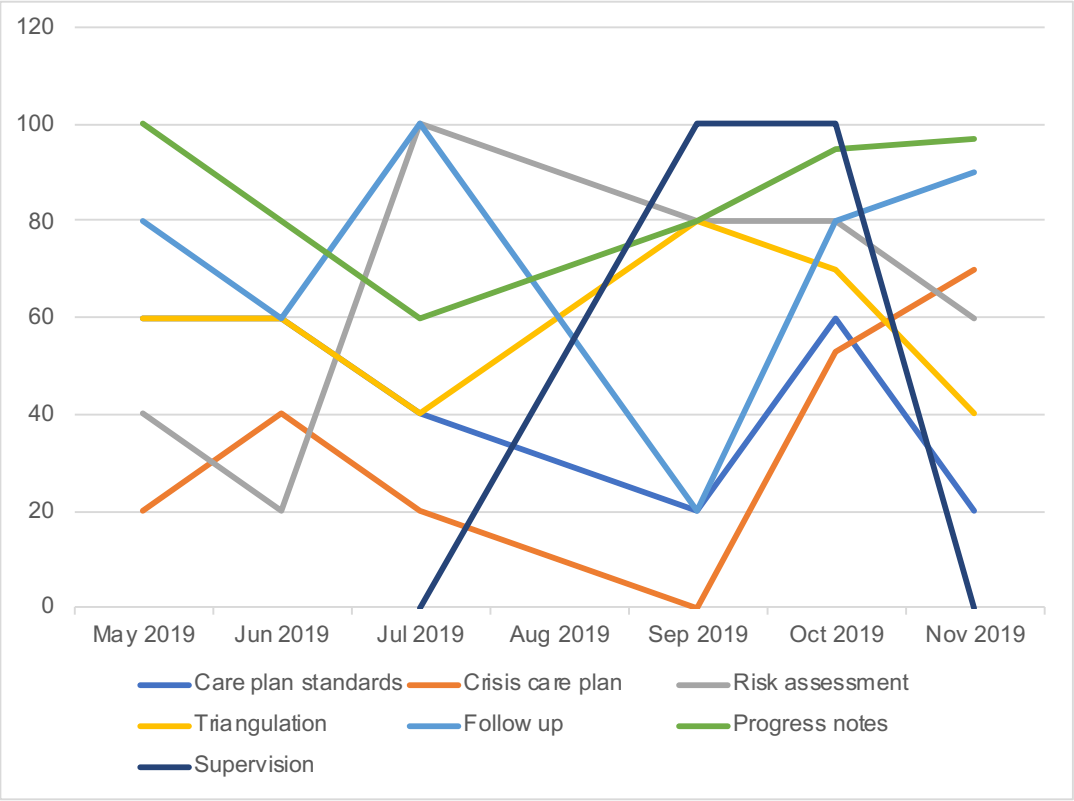
Trust recommendation 2

5.39 In March 2019 a meeting of Early Intervention in Psychosis managers documented that there was concern that several clinicians had not received PANSS training. This was documented as being offset by the fact that PANSS assessments were not being included in CLiQ[20] checks until the end of September 2019.

[20] CLiQ checks are clinical quality checks carried out by a senior Quality Lead and areas such as Care Programme Approach documentation, risk assessments, follow up when patients have not attended for appointments etc are audited against quality standards.

5.40 The CLiQ check dated 18 November 2019 for the South West team covered a review of 68 case notes. An email dated 18 November 2019 from the Clinical Quality Manager highlighted a concern of no improvement over the previous three months. It was acknowledged in that email that there were a number of clinicians that were new to the team and a request was made for a discussion about how the team could be supported to make the necessary improvements. Figure 3 below sets out the findings of the CLiQ checks undertaken between May and November 2019.

Figure 3: CLiQ check findings reported by the Trust



5.41 We have not seen any evidence to indicate any improvement in the CLiQ checks. Neither have we seen evidence that all staff are aware of and are actively implementing procedure outlined in the new Early Intervention in Psychosis Operational Policy launched in March 2019.

5.42 The Trust has reported that external audits have been conducted in three of the six localities for Early Intervention in Psychosis. Although the Trust has cited that the feedback was positive, we have not seen evidence of this.

5.43 The action plan documents that this action was closed on 12 March 2020.

Trust recommendation 3

5.44 The new policy provides clear guidance on which RAG category a patient should be rated if they are starting to disengage, or who are not engaging. The policy also provides clear guidance on the frequency patients in the different RAG categories should be discussed and what forum should be used (i.e., Red Board meetings, or staff supervision).

5.45 There is evidence of discussion about the new policy at business meetings.

5.46 The action plan documents that this action was closed on 19 November 2019.

Trust recommendation 4

5.47 We can see that an audit was completed for Red Board meetings held in May 2019, this included a random sample of patients who were discussed during this month. The Trust reported that of the ten patients included in the audit, all were discussed at the Red Board meeting, there was a management plan documented in their clinical records and there was evidence that actions had been completed.

5.48 We have not seen any other audit data that would enable us to state that the Trust is able to demonstrate a sustained improvement.

5.49 The action plan documents that this action was closed on 26 June 2019.

Trust recommendation 5

5.50 In November 2019 an audit of ten patient records (five for the East and five for the West) found evidence of only two carers packs being sent out and discussions with carers in one other case.

5.51 The Trust documented that actions were taken by a manager to address the audit results, but we have not been provided with details of these.

5.52 The Trust has also documented that the service manager had checked the process with the admin team who reported that carers packs do get sent out and it was likely to be a recording issue.

5.53 We have not seen any other evidence indicating that this issue has been resolved.

5.54 The action plan documents that this action was closed on 1 November 2019.

Trust recommendation 6

5.55 The Trust has taken action to address the issue of access to medical appointments by way of increasing the specialty doctor capacity and developing a business case for non-medical prescribing posts. However, the evidence we have seen shows that there remain significant waiting times for non-urgent appointments in the West, 16 weeks in Medway and Maidstone/ South West Kent.

5.56 The detailed action plan indicates that this action remains open and therefore we would expect to see further action being taken by the Trust.

Recommendation 1: The Trust must provide assurance to their commissioners that appropriate, timely and effective action is being taken to complete and embed the learning from the outstanding recommendations in their internal investigation relating to this case.

Clinical commissioning group oversight

5.57 At the time of the incident NHS West Kent CCG had responsibility for oversight of this serious incident. NHS West Kent CCG is a legacy organisation of NHS Kent and Medway CCG. Serious incidents were managed by a review panel with a remit based on the Serious Incident Framework. The panel was responsible for ensuring that the investigation report was adequate:

- Did it follow methodology?
- Were contributory factors appropriate?
- Was a root cause identified?
- Was there an action plan?

5.58 We were also told that if the panel was satisfied that the investigation report met the standards, the serious incident would be 'closed' on STEIS.

5.59 We were advised that no supporting documentation was available regarding the discussions and actions taken in relation to this investigation because there has been significant organisational change across the clinical commissioning groups since the time of the incident. Therefore, we have no evidence of any meetings between the CCG and the Trust to discuss the progress and oversight of this investigation.

5.60 On 1 April 2020 the eight clinical commissioning groups in the Kent and Medway area merged to become a single clinical commissioning group (NHS Kent and Medway CCG). This provided opportunity to strengthen and streamline the process for managing serious incidents.

5.61 The revised serious incident closure process is conducted through a panel consisting of:

- medical leaders;
- non-medical leaders;
- an expert in safeguarding; and
- a member of the patient safety team.

5.62 All members are required to be present in order for the meeting to be quorate. The panel's responsibility is to review the STEIS entry, submitted report and action plan and assess them against the standards set out in the Serious Incident Framework. The panel may request amendments, or further information from the submitting provider, and can reject the report if there are significant concerns about the quality. Once the report and action plan are accepted the incident is closed on STEIS.

5.63 A new fast track process has been implemented for serious incidents where an overarching improvement plan is likely to be in place for example (falls or pressure ulcers). The fast-track process was implemented a part of the response to the Covid-19 pandemic, but it is possible that it may remain after pandemic measure have ceased. The process allows for a serious incident to be closed on STEIS referencing the existing overarching plan. This allows for resources to be directed to serious incidents where there is a greater opportunity to identify new learning.

5.64 Following the merger of the CCGs there were plans to have a more robust approach to analysing action plans using a systematic thematic review process. This involves a selection of serious incidents that are then subject to thematic review looking a similarities of incident type, provider, location or learning. The process would include all types of investigations that generate learning including:

- Domestic Homicide Reviews.
- Serious Case Reviews.
- Safeguarding Adult Reviews.
- Learning Disabilities Mortality Review (LeDeR).

5.65 The output from the thematic review process would be used to inform quality assurance activities or quality improvement programmes, also using the 'soft intelligence' in the system stemming from complaints and less serious incidents.

5.66 However, the impact of the Covid pandemic has meant that staff and resources have needed to be redirected and this new approach has not yet been implemented. The clinical commissioning group is only undertaking

assurance activities for limited key lines of enquiry in accordance with directives from NHS England and Improvement – Reducing the Burden and Releasing Capacity.

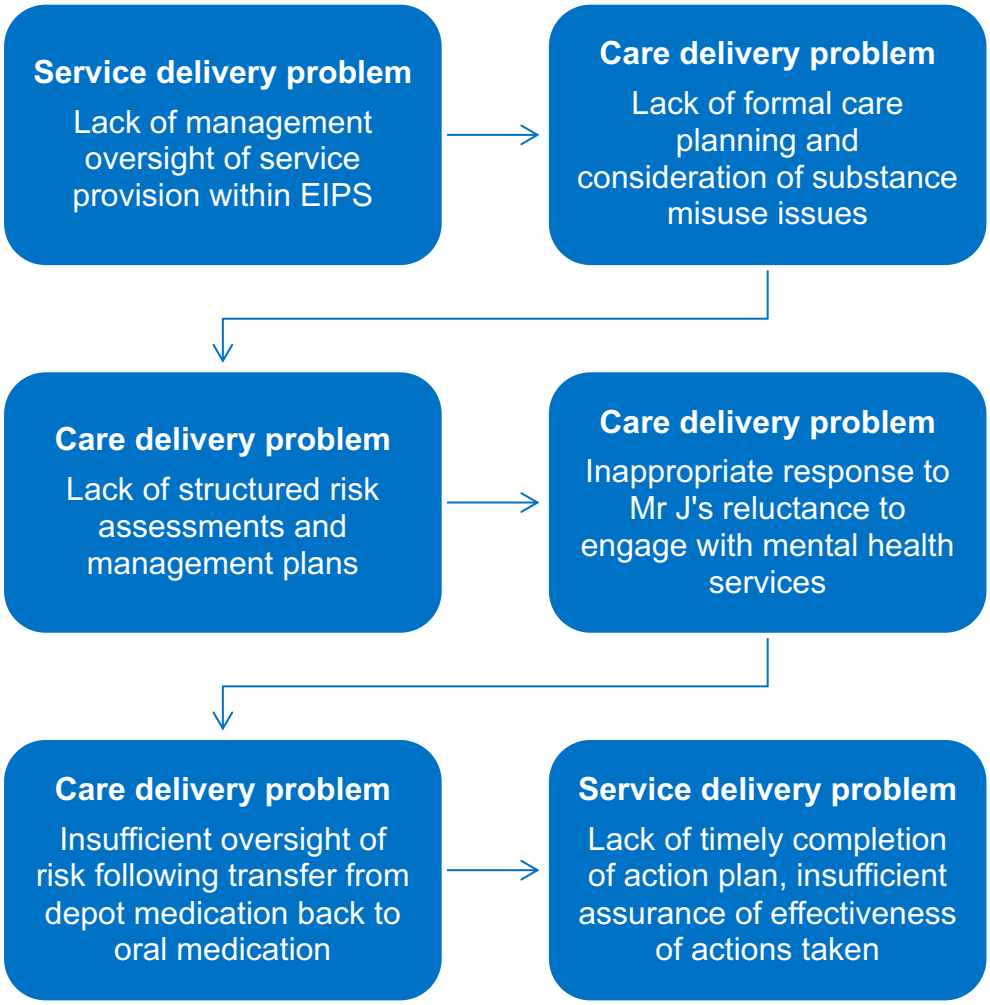
5.67 Notwithstanding the challenges in the system as a consequence of the Covid pandemic, the merger of the clinical commissioning groups has provided a greater opportunity for commissioners to see the whole picture and understand where improvements need to be made. This approach has been welcomed by providers, as it offers consistency regardless of location.

5.68 It is our view that the changes made by NHS Kent and Medway CCG to the management and oversight of serious incidents is a positive move. We recognise that the intention to make further improvements to the strategic effectiveness of the process has been hampered by the Covid pandemic.

6 Discussion and analysis of Mr J's care and treatment

6.1 We identified a number of care and service delivery problems associated with Mr J's care and treatment. We have summarised these in Figure 4 below and discuss them in further detail in the following sections.

Figure 4: Care and service delivery problems associated with Mr J's care and treatment, and subsequent actions



6.2 We have considered whether there were missed opportunities to engage other services and/or agencies, to support Mr J and his family. We have found no evidence to indicate that vulnerable adult processes should have been used in managing Mr J's presenting risks, for example:

- there is no indication that he presented a risk to his family that should have prompted a safeguarding adult referral;
- he had no criminal convictions that would have enabled the use of MAPPA processes.

Diagnosis

6.3 Mr J's diagnosis was documented as:

- 23 April 2017: "psychosis (nonorganic) Disorder…need to consider Schizophrenia…" by CP1.
- 27 April 2017: "psychosis" by CP2.
- 26 June 2017: "relapse of psychotic illness" by CP1.
- 24 July 2017: "psychotic disorder, possibly drug induced" by CP2.
- 29 January 2018: "psychosis not otherwise specified… (possibly schizophrenic, possibly drug induced)" by CP3.

6.4 We have benchmarked the interventions offered by the Trust against the NICE guidance for the prevention and management of psychosis and schizophrenia with the full analysis in Appendix I.

6.5 The treatment Mr J received for the management of his psychosis was broadly compliant with the NICE guidelines:

- There was good evidence of working in partnership with Mr J's mother.
- Numerous concerns about Mr J's weight reported by him and his mother were appropriately followed up by his care coordinator.
- Multi-disciplinary assessment of Mr J was completed in secondary care, although the consistency of the medical input was an issue.
- Medication and psychological interventions were offered.
- Mr J's views about the antipsychotic medication were taken into account, although this caused concerns about compliance.
- Mr J was offered access to support programmes to enable him to access occupational or educational activities.

6.6 Aspects of the guidance where more could have been done include:

- Carer' support for Mr J's mother. We can see that a carer's pack was provided to her when Mr J was admitted to hospital, but we have not seen any evidence that she was advised about her right to a formal carer's assessment. Indeed, when we met with her, she told us that she had not considered herself as Mr J's carer until staff at the secure hospital discussed this at length with her. We discuss carer's experience in more detail on page 52.
- We found no evidence that Mr J was offered peer support.

Medication

6.7 Aripiprazole is used as treatment for schizophrenia. The British National Formulary (BNF)[21] provides a dosing range of 10mg to 15mg daily, citing a "usual dose" of 15mg and a maximum dose of 30mg daily.

6.8 Mr J was first prescribed medication as treatment for psychosis in April 2017. The prescription of oral aripiprazole 10mg daily was issued by his GP on recommendation by the consultant psychiatrist following assessment.

6.9 On admission to hospital in June 2017 the consultant psychiatrist (CP1) made the decision to change oral medication to depot injection aripiprazole 400mg monthly because there were concerns about Mr J's compliance with oral medication. We consider this to have been an appropriate decision.

6.10 Oral aripiprazole 10mg was continued to be prescribed alongside the depot injection until 19 July 2017.

6.11 CP1 documented in the inpatient discharge letter that it was "extremely important" that Mr J was prescribed a depot injection in order to remain stable.

6.12 The depot injection was administered by CCO1 in Mr J's home. We heard from early intervention team staff they were expected to administer depot medication as part of their regular interactions with patients. The depot clinics run by community mental health team staff were not accessible to patients of the early intervention team, and early intervention team staff were not able to access the clinic room for this purpose.

6.13 The Trust has disputed the position given to us by early intervention team staff and has stated:

> "…staff can use/book a clinic room at the community mental health team base if needed in order to give depot injections to patients on their caseload. The depot clinics that are run by the community mental health team are for patients on the community mental health team caseload. EIP [Early Intervention in Psychosis] patients can be booked into these clinics if it was part of the transfer plan from EIP to the CMHT."

6.14 Mr J was often anxious prior to receiving the depot injection, stating a fear or phobia of needles. He also very quickly started talking about returning to oral medication and remained fixed on achieving this aim:

- 25 July 2017: Mr J told his support worker that he would only be prescribed the depot injections for three months and commented that the medication was poisoning him.

[21] British National Formulary (BNF) publications set out current best practice as well as legal and professional guidelines relating to the use of medicines www.bnf.org

- 31 August 2017: Mr J told his care coordinator that he believed he would only be on the depot injection for a further two months.

- 26 September 2017: Mr J was unhappy about receiving the depot injection and said it was making him ill. He asked to return to oral medication.

- 7 November 2017: Mr J was keen to discuss his medication with the consultant psychiatrist as he still wanted to stop the depot injection. His care coordinator advised that even if the consultant psychiatrist agreed to stop the prescription for the injection, Mr J would still be prescribed oral medication.

- 23 January 2018: Mr J had discussed a return to oral medication with his care coordinator. She had documented in a letter to his GP that this would be discussed with the consultant psychiatrist and that she would support the request because she believed he would be compliant "this time around".

- 29 January 2018: Mr J told the consultant psychiatrist (CP3) that he was not happy to continue with the depot injection and that he wanted to return to oral medication. CP3 agreed and prescribed aripiprazole 30mg and clonazepam 0.5mg for seven days to be taken as required.

6.15 The internal investigation team found that "it was probable that others would also" have taken the decision to agree to change Mr J's medication from depot injection back to oral medication. They went on to say that the decision was not followed up with an "appropriately robust level of monitoring" in the months that followed.

6.16 It would not have been possible to have enforced continued depot medication without previously having detained Mr J on Section 3 Mental Health Act and then implemented Community Treatment Order arrangements. The evidence we have seen does not lead us to believe that detention on Section 3 Mental Health Act would have been warranted. On this basis we agree that the decision to return to oral medication is defensible but there should have been a clear plan to monitor Mr J's mental state in a robust way, with clearly described relapse indicators, and a documented crisis plan.

6.17 We have not made a recommendation about monitoring the mental state of patients, nor about how staff respond to patients who are reluctant to engage with services as these issues were addressed in the internal investigation. We have made an earlier recommendation (Recommendation 1, page 33) about the implementation, embeddedness and effectiveness of the actions taken following the internal investigation recommendations.

Risk assessments

6.18 The Trust Clinical Risk Assessment Policy[22] describes risk assessment and effective management as a core component of mental healthcare and an integral part of the Care Programme Approach.

6.19 The Policy states that risk assessment should be "structured, evidence based and as consistent as possible…" so that:

- risks to the wellbeing of service users, staff and others are assessed and identified;
- indicators of possible adverse outcomes e.g., non-compliance with treatment or non-attendance at appointments are addressed;
- risks to service users, staff and others are regularly reviewed;
- risks to service users, staff and others are communicated appropriately; and
- shortfalls in services are identified and addressed.

6.20 The Policy cites the development of a framework of using the 3 Tiered Process (SAFE-T[23]) for assessing and managing clinical risk and that all staff responsible for formally assessing clinical risk should follow this process.

6.21 The Policy states that the primary risk assessment summary to be used by clinicians is the RiO[24] Risk Summary and it goes to provide a list of approved secondary risk assessment tools including:

- Short Term Assessment of Risk and Treatability (START).
- Functional Analysis of Care Environments and RAMAS: Risk Assessment and Management Tool (FACE).
- HCR-20 Assessment of the Risk of Violence.

6.22 In addition to the secondary risk assessment tools, there are also a number of approved tools that can be used as an aid to assess risk including:

- Hospital Anxiety and Depression, ACE-R (HAD).
- Becks Hopelessness Scale (BHS).

[22] Trust Clinical Risk Assessment and Management of Service Users Policy January 2017.

[23] Suicide Assessment Five-Step Evaluation Triage.

[24] RiO is the electronic patient record system in use by the Trust.

6.23 The Policy sets out key points at which risk must be assessed or reassessed and Safety Care Plans agreed, actioned and updated on a patient's clinical record:

- At first presentation to a Trust service or re-presentation to a Trust Service following discharge.
- On admission to an inpatient service.
- Within 48 hours or sooner of discharge from an inpatient service.
- When granting leave or discharging from a section.
- Prior to or during Care Programme Approach review or more frequently if Safety Planning is required.
- Prior to a patient moving from one service to another or prior to discharge from a ward or from other Trust services.
- At the point of detaining a patient under the Mental Health Act, granting leave, or discharge from a section.
- At least every six months if not previously re-assessed within the previous six months.
- As soon as relapse signs are indicated including deterioration in mental state.
- At any time of concern regarding patient safety or the safety of others.

6.24 We have not been able to identify that any detailed risk assessment tools were used by early intervention team staff in Mr J's case. The Risk Summary included in Mr J's clinical records details some consideration of risks, see Table 3 below.

Table 3: Risk summary

Date	Risk assessed by?	Detail
10 July 2017	West Kent Crisis Resolution and Home Treatment Team	Self: ward review – denied hearing voices, no psychosis symptoms exhibited nor reported.
11 July 2017	West Kent Crisis Resolution and Home Treatment Team	Self: denied thoughts of harm to himself and was not suicidal, no psychotic symptoms evident or reported. To others: no risks elicited.
16 July 2017	West Kent Crisis Resolution and Home Treatment Team	Self: denied any suicidal thoughts, plans and intent.

Date	Risk assessed by?	Detail
7 November 2017	Early Intervention in Psychosis Service	Self: currently attending to his self-care and diet, no evidence of any self-harm or suicidal thoughts. Protective factors: supported by his mother, brother and sister. Did not see father very often and currently reported that father told him that he was not ill and should not accept treatment. Previous risk to self: had lost a lot of weight after seriously restricting his diet, observed to be dehydrated after choosing to only drink rainwater.
4 June 2018	Early Intervention in Psychosis Service	Self: maintaining good self-care and wellbeing with no concerns around self-harm or suicidal ideation elicited. Protective factors: continued to be supported by his family and was engaging with the early intervention team. Recently got a job and was more social with others. Previous risk to self: no current risks elicited. To others: no risks elicited.
30 September 2018	Criminal Justice Liaison and Diversion Service	Self: recent (two years) history of psychotic illness. No previous acts of suicide/self-harm. Denied intent to harm himself, previous self-neglect linked to beliefs that he was being poisoned. Apparently engaging with mental health services but concealing symptoms. Arrested for murder and attempted murder. Protective factors: previous protective factors should not be assumed to be effective given Mr J's circumstances. Previous risk to self: no acts of self-harm or suicide recorded, previous self-neglect relating to beliefs that he was being poisoned. To others: believed his mother was at risk from his female neighbour and that she would stab his mother or run her over. Appeared compliant with treatment and engaged with care team. Appeared to have been able to conceal active psychotic symptoms from care team and others. Symptoms made dramatically worse by consumption of alcohol. Experienced loud command hallucinations telling him to kill his neighbours. Possible that Mr J may

Date	Risk assessed by?	Detail
		continue to conceal the extent of his symptoms in future and the symptoms may cause him to perceive threats from other that are not apparent to those around him. Risk is likely to be significantly and rapidly exacerbated by the use of alcohol, drugs or non-compliance with prescribed treatment.

6.25 The only safety plan documented is one created after Mr J attacked his neighbours. This refers to police, prison and escorting staff to be aware of the risk of self-harm and that a referral to prison mental health services would be made.

6.26 "Risk" is mentioned in Mr J's contemporaneous notes on a number of occasions. We have set these out in Table 4 below.

Table 4: Risk consideration within contemporaneous records

Date	Risk documented by?	Detail
11 July 2017	CCO1	No acute risks elicited.
24 July 2017	CP2	Risks remain very low and there are no psychosocial stressors.
4 August 2017	CCO1	No risks elicited.
26 September 2017	CCO1	Risk of not being compliant with medication if Mr J returned to oral medication, and consequential admission to hospital.
29 January 2018	CP3	Risk of relapse into psychosis (because oral medication was being restarted), risk of self-neglect. Risk to others not known.
4 June 2018	CCO1	No concerns or risks raised.
13 September 2018	CCO1	No risks elicited.

6.27 None of the consideration of Mr J's risks that were documented were done in a way that evidenced they were "structured, evidence based or consistent". This issue was raised in the internal investigation and two recommendations were made that link to risk assessment, safety planning/relapse prevention planning (Trust recommendations 1 and 4).

6.28 However, it is our view that further work is required to provide assurance about the use of structured and consistent risk assessments within the Early Intervention in Psychosis Service.

Recommendation 2: The Trust must provide assurance to their commissioners and the Board that within the Early Intervention in Psychosis Service risk assessments and risk management plans are completed, reviewed, updated and documented in accordance with organisational policy.

Care planning and use of Care Programme Approach

6.29 The Trust Care Programme Approach Policy provides the framework for the management of patients who have severe or complex mental health needs. This includes:

- professional support from a care coordinator;
- comprehensive multi-disciplinary, multi-agency assessment;
- comprehensive formal written care plan, including risk, safety, contingency, and crisis plan, references to NICE and best practice recommendations (where appropriate), shared with and explained to the patient; and
- ongoing review, formal multi-disciplinary, multi-agency review at least every six months.

6.30 Care Programme Approach should be used if people have "more complex needs, are at most risk or have mental health problems compounded by significant disadvantage". Indicators suggesting people are likely to need Care Programme Approach are listed and the Policy states that government guidance suggests that Care Programme Approach should be used if any of the indicators apply. Those indicators listed that could have been considered relevant to Mr J are:

- Severe mental disorder (including personality disorder) with a high degree of clinical complexity.
- Relapse history requiring urgent response.
- Self-neglect/non concordance with treatment plan.
- Current or significant history of severe distress/instability or disengagement.
- Presence of non-physical co-morbidity including substance/alcohol/ prescription drugs misuse, learning disability.
- An inpatient.
- Currently/recently detained under Mental Health Act, on Supervised Community Treatment or Guardianship, and most people subject to S.117 MHA or referred to crisis/home treatment teams.

6.31 The Policy states that Care Programme Approach has strong links with HoNOS[25]. HoNOS scoring can help assess a patient's level of functioning in a range of areas and can be a central part of measuring recovery. A series of scores can help patients and carers review development over a period of time and help people to identify their strengths and areas in which they may need more support.

6.32 The expectation is that for patients under Care Programme Approach there must be a full RiO Care Plan, for patients on standard care, the care plan may be within a GP letter.

6.33 Crisis and contingency plans are described as an agreed plan of action that is implemented in a crisis. It should provide the information and arrangements needs to prevent any unforeseen circumstances escalating into a crisis and should contain the information necessary for the continuation of a care plan in an interim situation. It may contain the following:

- possible early warning signs of a crisis and coping strategies;
- how the patient usually presents;
- protective factors;
- support available to help prevent hospitalisation;
- where the person would like to be admitted in the event of hospitalisation;
- whether (and the degree to which) families or carers are involved; and
- information about 24-hour access to services.

6.34 Mr J was detained under Section 2 of the Mental Health Act in June 2017, was under the care of the crisis team on discharge and was known to have co-morbid substance misuse issues. He therefore should have been managed under Care Programme Approach.

It is our assessment that he was being managed under Care Programme Approach. However, there was only one Care Programme Approach care plan and very few references to Care Programme Approach reviews and care plans in Mr J's clinical records. We have set these out in

[25] HoNOS (Health of the Nation Outcome Scales) is a method of measuring the health and social functioning of people with severe mental illness. It is comprised of 12 scales that measure behaviour, impairment, symptoms and social functioning.

6.35 Table 5 below.

Table 5: References to Care Programme Approach reviews and care plans

Date	Reference	Detail
27 July 2017	Letter from CP2	Letter to Mr J's GP in which CP2 documented the following care plan: Medication to continue (aripiprazole depot injection 400mg). Care coordinator to continue to support and monitor mental health in the community. Contact details for acute services available Review in outpatient clinic as necessary.
6 September 2017	Letter from CP2	Letter to Mr J's GP in which CP2 documented the following care plan: Medication to continue (aripiprazole depot injection 400mg) and Mr J agreed not to have any reduction. Contact details for acute services available. Care coordinator to continue to support and monitor mental health. Happy to keep engaging with services and comply with medication.
7 November 2017	Care Programme Approach review	Documented in Mr J's contemporaneous records. Held with CCO1 and Mr J. The entry touches on unmet needs, views of Mr J and his mother, what worked well, and what did not work well. It documented that Mr J was declining all interventions because he did not believe that he had a mental disorder and that he could manage without treatment. Mr J's mother remained highly concerned for his mental health and his cognitive ability. She felt that Mr J's reluctance to engage with mental health services may lead to a relapse. Mr J's engagement with services was cited as not having worked well, although there had been some recent improvement and stabilisation in his mental health. There is no associated care plan, crisis/contingency plan or safety plan.
4 June 2018	Care Programme Approach review	Documented in Mr J's contemporaneous records. Held with CCO1 and Mr J. The entry touches on unmet needs, views of Mr J and his mother, what worked well, and what did not work well. Mr J had a job and was happy about this, he was going out more and was taking aripiprazole 30mg. He voiced no concerns or worries.

Date	Reference	Detail
		Mr J's mother had previously raised a concern that he may have been using cannabis with his girlfriend, but no use was detected at that time. Medication and engagement with early intervention services was cited as having worked well. There is no associated care plan, crisis/contingency plan or safety plan.

6.36 We found no evidence of HoNOS scoring being used to monitor Mr J's functioning.

6.37 The lack of use of objective assessment tools and the lack of comprehensive care planning documentation is particularly concerning given the complexity of Mr J's presentation and the degree and duration of the concerns documented about his engagement and honesty about his symptoms and compliance with medication.

6.38 We heard from early intervention team staff that just prior to the incident involving Mr J, members of the team were reviewing policies in preparation for a court hearing relating to a different patient. We heard that staff found that there were multiple instances where the team were not following the Trust policy. The assessment by the staff involved was that their "leadership and direction had been lost" and that there had been insufficient oversight of how the team functioned in the period prior to 2017.

6.39 The Trust internal investigation made a recommendation about staff within the Early Intervention in Psychosis Service being aware of, and actively implementing the procedures in the new Operational Policy implemented in March 2019. Our assessment set out in Section 5 found that further work was required to implement and embed the recommendation made in the Trust internal report. We made a recommendation in that section (Recommendation 1, page 33) and have therefore not added anything further here.

Use of illicit substances

6.40 The Trust Dual Diagnosis Policy[26] states that all patients under the care of the Trust will have "full and continuing assessment" of their needs in relation to the use of illicit substances.

6.41 The policy is clear that where the patient has significant mental health needs, the Trust will work with other agencies to support identified needs and that a care plan will be created, written in accordance with the Care Programme Approach Policy.

[26] Dual Diagnosis Policy November 2015.

6.42 The assessment conducted by the inpatient team during Mr J's detention on Section 2 Mental Health Act concluded that Mr J was suffering from "mental and behavioural disorders due to substance misuse". The discharge document completed on 10 July 2017 stated that Mr J had agreed to seek help from the local substance misuse service "to help him stay clear of recreational drugs".

6.43 We found no evidence that this aspect of Mr J's discharge plan was ever followed up after his discharge from inpatient services. Equally we found no evidence in Trust records that Mr J was ever engaged with the local substance misuse service.

6.44 Use of recreational drugs rarely featured in Mr J's contemporaneous records after discharge from inpatient care:

- 1 September 2017 – Mr J talked briefly about previously being poisoned by cannabis, when CCO1 attempted to expand on the discussion Mr J became agitated.
- 24 May 2018 – Mr J's mother reported to CCO1 that she was concerned he was using cannabis again but expressed concern that CCO1 should not share with Mr J that she had shared the information about him.
- 4 June 2018 – CCO1 documented that Mr J's mother had previously raised concern that Mr J had been using cannabis but that "no current use" had been detected. (It is unclear from the entry how that had been determined.)

6.45 There were no further references to substance misuse until after the incident on 29 September 2018.

Recommendation 3: The Trust must ensure that where appropriate, the Dual Diagnosis Policy is understood and actively implemented by clinical staff.

Engagement with Mr J and his family and carer experience

6.46 The Trust Policy and Procedure for Managing and Reducing Did Not Attend (DNA) states clearly that the purpose of the policy is to "reduce the incidence of people not attending appointments and to ensure the safety and wellbeing of the people involved". It further states that "some people may pose a risk to themselves of others" if they do not maintain contact with the Trust.

6.47 The Operational Policy for the East Kent Early Intervention in Psychosis Service July 2008 (Draft) was the only document covering the operational function of the service at the time. This document covers non-engagement with the Early Intervention in Psychosis Service and states:

"In a situation where a person is reluctant to have contact with the team either for assessment or for ongoing treatment, the team will use the following processes:

- As full a risk assessment as possible will be undertaken to determine if a Mental Health Act assessment is required for the safety of the person or of others.

- If this is felt not to be necessary, then plans will be made to monitor the situation with a view to engaging the person at a later stage. This could include keeping in touch by phone or text messages, offering practical support with such things as housing and finances, offering purely social contacts in non-stigmatising settings, and keeping in contact through carers while offering them information and support.

- If, after three months of attempts by the team to assess a person with no previous history, no further contact or evidence of deterioration has occurred, the person will be discharged back to the referrer with a contingency plan for re-referral.

- If the person has had one or more episodes of psychosis, they will remain on the team caseload for up to 12 months before discharging them back to primary care."

6.48 The Operational Policy also discusses the role of carers:

- Carers/families are seen as central to the well-being of EIPS [Early Intervention in Psychosis Service] clients and as partners in the provision of care.

- Carers/families are engaged in each stage of the EIPS [Early Intervention in Psychosis Service] intervention process.

- Seeking information, advice, and support for the intervention process from families is also seen as central to the role of EIPS [Early Intervention in Psychosis Service].

- The improvement of EIPS [Early Intervention in Psychosis Service] relationships with carers/families of clients is an ongoing aim of the EIPS [Early Intervention in Psychosis Service].

6.49 Following discharge from hospital in July 2017 there was intensive input from staff in the early intervention team, however this reduced notably from late 2017, early 2018. Table 6 below provides a summary of the number and type of contacts with Mr J and his mother from July 2017 to September 2018.

Table 6: Number of contacts with Mr J and his mother

Month	Number of face-to-face contacts with Mr J	Number of telephone or text contacts with Mr J	Number of telephone or text contacts with Mr J's mother
July 2017	7	0	1
August 2017	5	0	3
September 2017	5	0	0
October 2017	1	3	0
November 2017	1	0	0
December 2017	1	0	1
January 2018	2	0	1
February 2018	1	3[27]	1
March 2018	1	0	1
April 2018	0	0	0
May 2018	0	1	1
June 2018	1	0	1
July 2018	1	0	1
August 2018	0	1	0
September 2018	0	2	1

6.50 Mr J was reluctant to accept that he had a mental disorder and often kept early intervention team staff at arm's length, but it was rare that he did not attend for an arranged appointment.

6.51 Mr J's mother reported concerns about cannabis use in May 2018 and in June 2018 she told CCO1 that she believed that Mr J was masking his symptoms and only giving the appearance of being compliant in order that he would be discharged from mental health services. Mr J's mother reported further concerns in July 2018 but despite concerns being raised over three consecutive months there was no face-to-face contact with Mr J from 4 June 2018.

6.52 We found no evidence that the concerns raised triggered a formal review of Mr J's risk assessment or care plan.

6.53 The internal investigation made a recommendation (recommendation 4) about monitoring risk assessment and management plans, implementing the use of RAG rating patients according to the level of current needs and risk, and the use of Red Board meetings to discuss those patients with the highest level of risk.

[27] These exchanges were with vocational support staff.

6.54 The Trust has provided evidence of the patients categorised as Red being discussed at the Red Board meetings, but it is our opinion that further evidence (for example audits and CLiQ checks) is required to provide assurance that risk assessments and management plans are being reviewed and updated when appropriate.

Carer experience

6.55 The Trust advised that they do not have a policy specifically for carers' assessment or support and that all aspects of carer support are dealt with in policies covering Care Programme Approach, and admission and discharge.

6.56 The Care Act requires each local authority to establish and maintain a service providing information and advice relating to care and support for adults and support for carers.

6.57 The Trust website states that if someone would like to have a carer's assessment they can:

- contact the patient's social worker or community mental health nurse; and
- contact the relevant social services department directly.

6.58 The Trust website also provides information about Involve Carers, an organisation that provides support to carers.

6.59 The Care Programme Approach Policy in place at the time describes the role of carers in supporting patients as being integral to the Care Programme Approach process.

6.60 It states that carers should be identified on electronic patient record system by making a carer's record and documenting the appropriate assessment data within the Core Assessment. It further states that all carers are entitled to:

- "Have their views and concerns listened to and respected.
- Have choice about whether to continue in the caring role.
- Be given information about CPA and care planning.
- Know who to contact in an emergency.
- Receive prompt and positive responses to requests for help.
- Be signposted to relevant authorities within public sector if applicable.
- To be identified and told by the Care Coordinator/named professional that they have a legal right to have their health and social care needs assessed (see No Health without Mental Health 2011).

- When a carer has received a carers assessment to have formulated a 'Carers care plan' detailing interventions which should help inform the service users care plan, recorded on Care Planning Carer section on RiO.

- For teams who are not within the Partnership agreement (Older Adults and Medway), a referral will be made to either Medway Council or [Kent County Council] KCC following current protocols and agreements."

6.61 The records completed during Mr J's admission to hospital in June 2017 indicate that his mother was invited to attend the Priority House carers support group and that she received a carers pack when she visited Mr J.

6.62 When we met with Mr J's mother, she told us that she did not realise that she was a carer and that she could not recall any discussion by Trust staff with her about a carer's assessment. She also told us that that nobody mentioned anything about the Triangle of Care.[28] This was a missed opportunity for staff to ensure that Mr J's mother understood her role and what support she was entitled to.

6.63 There is good evidence that the information given, and concerns raised by Mr J's mother were documented but there was less evidence that appropriate actions was always taken after information was received by staff. We consider this to have been a significant missed opportunity for staff to intervene in the decline of Mr J's mental state.

Triangle of Care

6.64 The Triangle of Care guide was launched in July 2010 by The Princess Royal Trust for Carers (now Carers Trust) and the National Mental Health Development Unit to highlight the need for better involvement of carers and families in the care planning and treatment of people with mental ill health.

6.65 The Trust stated that the organisation successfully completed their first audit for inpatient services in 2017 and achieved the second Triangle of Care star for the community services audit in May 2019.

6.66 The Trust provided us with a copy of the Triangle of Care self-assessment tool completed by the Early Intervention in Psychosis Service. The date of completion is not clear and there are a range of completion dates from March 2018 to June 2020.

6.67 The self-assessment tool uses a Red/Amber/Green approach to assess 39 criteria across six standards. We have provided a summary of the Trust's self-assessment scoring in Table 7 below.

[28] The Triangle of Care describes a therapeutic relationship between the patient, staff member and carer that promotes safety, supports communication and sustains wellbeing.

Table 7: Triangle of Care - Trust self-assessment summary

Standards	Red criteria	Amber criteria	Green criteria
Standard 1 – Carers and their essential role are identified at first contact or as soon as possible afterwards. (Seven criteria)	1	5	1
Standard 2 – Staff are carer aware and trained in carer engagement strategies. (Three criteria)	3	0	0
Standard 3 – Policy and practice protocols re: confidentiality and sharing information, are in place. (Nine criteria)	1	4	4
Standard 4 – Defined post(s) responsible for carers are in place. (Three criteria)	0	1	2
Standard 5 – A carer introduction to the service and staff is available, with a relevant range of information across the care pathway. (11 criteria)	0	7	4
Standard 6 – A range of carer support is available. (Six criteria)	1	3	2
Total R/A/G	6	20	13

6.68 We explore the criteria self-assessed as red below:

- 1.7 Carer has access to advice re: advocacy, equipment, and welfare rights. The Trust indicated that dedicated social care provision within the Early Intervention in Psychosis Service would be confirmed by December 2019.

- 2.1 All staff have received carer awareness training. The Trust indicated that they were awaiting confirmation of carer awareness training and that all staff would complete it when available, to be completed by March 2020.

- 2.2 The training referred to in 2.1 above includes a range or specific aspects of carer support.

- 2.3 The training referred to in 2.1 above is delivered by carer trainers or carers are part of the training delivery team.

- 3.7 Advance statements or directives are routinely used. The Trust indicated that an audit of patient care plans with a carer involved would be conducted to evidence the use of advance statements or directives, to be completed by March 2020.

- 6.5 The carer's needs and plan are regularly re-assessed. The Trust indicated that an early audit showed that the Early Intervention in Psychosis Service was poor at reviewing and recording information after an initial carer's assessment had been conducted. Improvements in

carers care plans would be reviewed on at least an annual basis or as needed if a crisis occurs, to be completed by April 2020.

6.69 It is our view that the Trust has made progress in the breadth and quality of the support staff offer to carers, but the crucial element of staff awareness carer engagement strategies needs more focus.

6.70 The Trust has indicated in the self-assessment document that e-learning is being developed for carer awareness. This approach fails to recognise the third criteria in this standard that requires training to be delivered by carer trainers, or that carer trainers are part of the training delivery team. In addition, the Trust has provided no narrative on this criterion within the self-assessment.

6.71 The guidance notes provided state that it is "vital that carers are part of the training team, if carers are not consistently delivering training this cannot be marked green". We have not made an associated recommendation because this aspect of work is referring to best practice. However, we would suggest that the Trust review the approach indicated in the self-assessment and consider how carers could be involved in the development and/or delivery of training in awareness of carer engagement strategies.

Interface between the Early Intervention in Psychosis Service and the Trust's out of hours services

6.72 The draft Early Intervention in Psychosis Service Operational Policy in place at the time stated that crisis intervention provision was provided by East Kent Crisis Resolution and Home Treatment team.

6.73 The Crisis Resolution and Home Treatment Operational Policy in place at the time stated that the role of the Crisis Resolution and Home Treatment Team included providing support to patients who, in the absence of the team, would have to remain in hospital. The policy makes reference to the interface with the patient's care coordinator and clearly states that it is not the function of the Crisis Resolution and Home Treatment Team to take on the role of care coordinator.

6.74 The new Early Intervention in Psychosis Service Operational Policy states that outside of core working hours referrals can be made via email and that if an urgent response is required, referrers are directed to the Crisis Resolution and Home Treatment Team. Where a patient known to the early intervention team presents in crisis outside core working hours, the responsibility to respond rests with the Crisis Resolution and Home Treatment Team, "as in all AMH [adult mental health] cases".

6.75 The interface is clearly described in current operational policies for the Early Intervention in Psychosis Service and the Crisis Resolution and Home Treatment team.

Local policy review standards

6.76 The standards for the management of Trust documents in place in September 2018 were described in the Development, Approval and Management of Formal Trust Documents – Policy and Procedures. This document is described as being in place "in order to ensure a consistent, high quality level of service provision across the whole organisation".

6.77 The policy also states that its purpose is to ensure that:

- All policies are developed and reviewed within a clearly defined accountability framework.
- Staff involved in the process have access to appropriate guidance and support.
- All new policies are generated due to a clearly identified need.
- There is consistency in the development, implementation and review of all Trust policies.
- All Trust policies are compliant/consistent with the Trust's strategic objectives, national guidance and relevant legislation.
- Appropriate consultation takes place when policies are being developed.
- All policies are properly disseminated throughout the Trust.
- Appropriate training is provided to staff.
- All policies are subject to regular review of their effectiveness.
- Correct ownership for all policies developed …"

6.78 The approval framework for different types of documents is described within standard operating procedures (such as Early Intervention in Psychosis Service Operational Policy) being owned by the care group team and being controlled by the care group governance groups. Clinical policies have to be ratified by either:

- Patient Safety Group.
- Clinical Effectiveness Group.
- Patient Experience Group.

6.79 The Trust Policy Manager is responsible for ensuring that the Development and Management of Trust Documents Policy is adhered to and that controlled numbering is in place for all formal documents.

6.80 The Policy states that all policies must be reviewed at least every three years and that the accountable director is responsible for the review process.

6.81 The Trust internal investigation identified that there was a ten-year gap in the Early Intervention in Psychosis Services Operational Policy and that it was "insufficiently robust".

6.82 The Early Intervention in Psychosis Services Operational Policy that we have reviewed that was in place at the time shows that it was a draft policy. We have seen no evidence that it was ever formally ratified.

6.83 It is of significant concern that a service could operate for more than ten years with no formally ratified operational policy or procedure, and it remains unclear how this position could have continued for so long.

6.84 The new Early Intervention in Psychosis Services Operational Policy has been written in accordance with the Trust policy template and was implemented in March 2019.

6.85 We have reviewed a number of Trust policies for this investigation and have set out below our findings in Table 8 below regarding policy review dates. It is important to note that we received all the policy documents in December 2019.

Table 8: Policy review dates

Policy	Date implemented	Review date	In date at time of receipt by Niche?	Niche comment
Investigation of serious incidents, incidents, complaints and claims policy.	January 2017	December 2019	Y	This policy was due to have been reviewed the month we received it, but as can be seen the policy below was actually reviewed and implemented prior to this one expiring.
Management and Investigation of Serious Incidents Policy.	September 2019	September 2022	Y	
Acute Inpatient Service Operational Policy.	January 2016	January 2019	N	This policy should have been reviewed 11 months before it was sent to us. We were advised that it was the policy in place as of December 2019.

Policy	Date implemented	Review date	In date at time of receipt by Niche?	Niche comment
Clinical Risk Assessment and Management of Service Users Policy.	January 2017	October 2019	N	Due to have been reviewed two months prior to us receiving it. Is there an updated policy?
Community Mental Health Teams Operational Policy.	October 2018	October 2019	N	Due to have been reviewed two months prior to us receiving it. This replaced the policy in place at the time of the incident that should have been reviewed in May 2016 but was still in place in September 2018.
Crisis Resolution and Home Treatment Service Operational Policy (Standard Operating Procedure).	September 2019	September 2020	Y	This policy was in date, but the policy provided as being in place at the time of the incident should have been reviewed in July 2018. The version control page shows that the policy was being reviewed between April and September 2019.
Policy and Procedure for managing patients who did not attend (DNA) and/or are unable to be contacted.	February 2018	February 2021	Y	This policy was in date.
Care Programme Approach Policy.	September 2019	September 2022	Y	The policy provided as being in place at

Policy	Date implemented	Review date	In date at time of receipt by Niche?	Niche comment
				the time of the incident should have been reviewed in October 2018; this was not completed until January 2019.
Dual Diagnosis Policy.	March 2019	March 2022	Y	This policy was in date.
Duty of Candour – Being Open Policy.	February 2015	February 2017	N	This policy was provided as being in place at the time of the incident; 18 months after this policy should have been reviewed.
Duty of Candour – Being Open Policy.	April 2019	April 2022	Y	This policy replaced the one referenced above. It was not implemented until more than two years after the previous policy should have been reviewed.
Procedure for dealing with the death of an inpatient.	January 2014	January 2017	N	This policy was provided as being in place at the time of the incident; 19 months after this policy should have been reviewed.

Policy	Date implemented	Review date	In date at time of receipt by Niche?	Niche comment
Procedure for the immediate care and response to a patient's unexpected death in community and inpatient settings.	September 2018	September 2021	Y	This policy replaced the one referenced above.
Health and Social Care Records Policy.	September 2017 September 2019	September 2019 September 2021	Y	This policy was in date and was reviewed in a timely fashion.

6.86 There have been a number of occasions when key Trust policies have not been reviewed in a timely fashion following the stated review date of the previous policy.

Recommendation 4: The Trust must provide assurance to the Board and its commissioners that formal operational procedures exist for all services and that those procedures have been reviewed within the appropriate timeframe in accordance with the Trust's own Policy on the management of policies.

7 Conclusions and recommendations

Predictability and preventability

7.1 Predictability[29] is "the quality of being regarded as likely to happen, as behaviour or an event". An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[30]

7.2 It is our view that the Trust could not have predicted that Mr J would attack his neighbours. There were no reports of violent outbursts or threats of violence being made prior to this tragic incident.

7.3 Prevention[31] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction". Therefore, for a homicide to have been preventable, there would have to be the knowledge, legal means, and opportunity to stop the incident from occurring.

7.4 However, Mr J had previously not been compliant with oral medication and had only been on depot medication for six months when it was agreed he could return to oral medication.

7.5 There was no robust plan to continue to monitor Mr J's mental state and Mr J was seen for face-to-face appointments on just six occasions between returning to oral medication on 16 January 2018 and the incident involving his neighbours on 29 September 2018.

7.6 Despite concerns that Mr J's psychosis was drug induced, and exacerbated by the use of cannabis, there was little emphasis on accessing substance misuse services and no evidence of any communication between the community mental health teams and the substance misuse service.

7.7 There were concerns expressed by Mr J's mother about his declining mental state in June, July, and September 2018. Despite these concerns being raised there had been no face-to-face contact with Mr J since 16 July 2018.

7.8 The content of the concerns raised by Mr J's mother included:

- Mr J masking his symptoms.
- Mr J storing rainwater in the freezer and underneath his bed.

[29] http://dictionary.reference.com/browse/predictability

[30] Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120

[31] http://www.thefreedictionary.com/prevent

- an inability to raise her concerns in the presence of Mr J in case she upset him.

7.9 In addition, in July Mr J's care coordinator described him as being irritable, agitated and guarded and documented that his appearance was similar to when he had been unwell previously.

7.10 It is therefore our view that there were clear indicators that Mr J's mental state was declining and that arrangements should have been made for a face-to-face assessment. It is also our view that Mr J's care coordinator would have benefitted from the opportunity to discuss Mr J's case with another member of staff in order to identify the most appropriate way to respond to the concerns that had been raised.

7.11 There was a missed opportunity for staff to intervene in the decline of Mr J's mental health in the period August to September 2018, when a robust face-to-face assessment should have been conducted. It is not possible for us to say what the outcome of that assessment would have been. However, it is possible that staff may have offered an inpatient admission in order to monitor Mr J's compliance with medication.

7.12 If at that point Mr J had refused to cooperate, it is possible that a Mental Health Act assessment may have been conducted. Again, it is not possible for us to state what the outcome of a Mental Health Act assessment might have been at that point.

7.13 Therefore, we cannot say with certainty that a more robust approach would have prevented the deaths and serious injury to Mr J's neighbours, but it would have reduced the likelihood of this happening.

Recommendations

7.14 This independent investigation has made five recommendations to improve commissioning and clinical practice.

Recommendation 1: The Trust must ensure that the policy on engaging with families of victims of homicide committed by patients known to mental health services reflects best practice set out in the NHS England (London) Investigation guidance issued in April 2019 on engaging with families after a mental health homicide.

Recommendation 2: The Trust must provide assurance to their commissioners that appropriate, timely and effective action is being taken to complete and embed the learning from the outstanding recommendations in their internal investigation relating to this case.

Recommendation 3: The Trust must provide assurance to their commissioners and the Board that within the Early Intervention in Psychosis Service risk assessments and risk management plans are completed, reviewed, updated, and documented in accordance with organisational policy.

Recommendation 4: The Trust must ensure that where appropriate, the Dual Diagnosis Policy is understood and actively implemented by clinical staff.

Recommendation 5: The Trust must provide assurance to the Board and its commissioners that formal operational procedures exist for all services and that those procedures have been reviewed within the appropriate timeframe in accordance with the Trust's own Policy on the management of policies.

Appendix A Terms of reference for independent investigation

Purpose of the investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that [Mr J] received, which, contributed the incident that took place on 29th September 2018. The investigation should identify opportunities for learning and areas where improvements to local, regional and national services may be required to prevent similar incidents from occurring.

The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and the Providers.

Terms of reference

NB: The following Terms of Reference remain in draft format, until they have been reviewed at the formal initiation meeting and agreed with the families concerned.

Kent and Medway Partnership NHS and Social Care Partnership Trust (KMPT) commissioned a level 2 investigation following the incident on 29 September 2018.

This investigation will build on that review in the following areas:

1. Review the care and treatment Mr J received from KMPT from 10 July 2017 following discharge from an inpatient admission, specifically:

    - The appropriateness of any diagnosis and treatment plans, and whether they were evidence based and in line with best practice guidelines/national guidance.

    - The quality of the risk assessments, risk management and crisis plans in place in the months leading up to and including the fatal incident.

2. Determine whether there were any missed opportunities to engage other services and/or agencies, to support Mr J and his family and manage any presenting risks, for example vulnerable adult processes.

3. Review the trusts governance processes in ensuring that all trust policies are contemporaneous and in line with national guidance and best practice.

4. Review the interface between the Early Intervention Service and the Trust's Out of Hours Services.

5. Review the Trust's level 2 RCA Investigation and assess its quality and the adequacy of its findings, recommendations and subsequent action plan and identify:

    - If the investigation satisfied its own terms of reference.

    - If all key issues and lessons have been identified and shared.

- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt.

- Review progress made against the action plans including evidence of change to local practice and process.

6. To review and comment on KMPT and/or the CCGs enactment of the Duty of Candour.

7. To assess and review any contact made with the victim and perpetrator families involved in this incident against best practice and national standards.

8. To review the Trust's family engagement policy for homicide and serious incidents, measured against best practice and national standards.

9. To review and test the Trusts and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with reference to this incident.

10. Assist the family of the victims and perpetrator in the production of a personal statement for inclusion in the final published report, if appropriate.

Timescale

11. The investigation process starts when the investigator receives all the clinical records, and the investigation should be completed within six months thereafter.

Initial steps and stages

NHS England will:

- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference.

- Arrange an initiation meeting between the Provider, commissioners, investigator and other agencies willing to participate in this investigation.

Outputs

12. We will require monthly updates and where required, these to be shared with families.

13. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.

14. A chronology of Mr J's mental health history from February 2017.

15. A clear and up to date description of the incident and any Criminal or Coroner Court decision (e.g., sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.

16. A set of SMART recommendations that have been co-produced with the organisation(s) concerned.

17. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proofread, shared and agreed with participating organisations and families (NHS England style guide to be followed).

18. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to discuss the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

19. A concise and easy to follow presentation for families.

20. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.

21. A briefing document of key learning points that can be shared with the Regions CCGs and Providers.

22. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

23. The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

Other

24. Should the family formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

Appendix B Documents reviewed

Trust documents

- Clinical records for Mr J
- Internal investigation report
- Action plan
- Transcripts from interviews conducted as part of the internal investigation
- Communications with Mr J's mother
- Communications with Mr J's father
- Communications with the police and Mr H regarding contact with Mr H
- Early Intervention in Psychosis Service Operational Policy Draft 6
- Early Intervention in Psychosis Service Operational Policy implemented in March 2019
- Community Mental Health Team Operational Policy in place in February 2017
- Community Mental Health Team Operational Policy in place in January 2020
- Crisis Resolution and Home Treatment Team Operational Policy in place in February 2017
- Crisis Resolution and Home Treatment Team Operational Policy in place in January 2020
- Did Not Attend Policy in place in February 2017
- Did Not Attend Policy in place in January 2020
- Acute Inpatient Operational Policy in place in June 2018
- Clinical Risk Assessment and Management Policy in place in 2017/18
- Care Programme Approach Policy in place in 2017/18
- Care Programme Approach Policy in place in January 2020
- Record Keeping Policy in place in 2017/18
- Record Keeping Policy in place in January 2020
- Duty of Candour Policy in place in 2017/18

- Duty of Candour Policy in place in January 2020
- Serious Incident Policy in place in 2017/18
- Serious Incident Policy in place in January 2020
- Dual Diagnosis Policy in place in 2017/18
- Dual Diagnosis Policy in place in January 2020
- Dual Diagnosis Joint Working Protocol
- Triangle of care documentation
- Death of a Patient Protocol in place in 2017/18
- Death of a Patient Protocol in place in January 2020
- National Audit of Early Intervention in Psychosis services and associated action plans
- Board Assurance Framework September 2018
- Clinical Risk training package
- Risk assessment tool to determine risk of violence to others in place in 2017/18
- Risk assessment tool to determine risk of violence to others in place in January 2020
- Policy for the management and review of Trust policies

Other documents

- GP clinical records

Appendix C Professionals involved

Pseudonym	Role and team	Organisation
CCO1	Early Psychosis Care Coordinator	West Kent EIPS
CJLD1	Criminal Justice Liaison and Diversion Service Person	KMPT
CP1	Consultant Psychiatrist	Priority House, KMPT
CP2	Consultant Psychiatrist	
CP3	Consultant Psychiatrist	EIPS, KMPT
EIPS1	Unknown	EIPS, KMPT
EIPS2	Team Leader	EIPS, KMPT
EIPS3	Unknown	EIPS, KMPT
GP1	General Practitioner	Hadlow Medical Centre
GP2	General Practitioner	Hadlow Medical Centre
GPST1	GP specialty trainee	Priority House, KMPT
GPST2	GP Specialty trainee	Priority House, KMPT
PH1	Staff Nurse	Priority House, KMPT
PH2	Ward Pharmacist	Priority House, KMPT
PH3	Psychiatric Nurse	Priority House, KMPT
PH4	Clinical Nurse	Priority House, KMPT
STR1	Support Time and Recovery Worker	EIPS, SKW KMPT
VR1	Unknown	Vocational Rehabilitation, West KMPT

Appendix D Chronology of Mr J's care and treatment

Date	Source	Event	Summary
10/07/2017 10:16	KMPT	Progress notes	CP1, GPST2, GPST1, PH1, PH3, PH2, PH4 completed ward round with the support of Mr J's mother. Mr J was stable and planned discharge was due that day. CCO1 to continue Mr J's review and could potentially administer Mr J's depot. Mr J agreed to EIPS support and the depot. PLAN: Discharge today. Continued support from CCO1. Section to be removed. Aripiprazole tablets to continue for two weeks.
10/07/2017 11:00	KMPT	Progress	Mr J was discharged with 9 days medication.
10/07/2017 14:18	KMPT	Progress notes	Mr J was referred to CRHT for post discharge monitoring. Home visit to be arranged due to referral being made after Mr J was discharged from hospital.
10/07/2017 20:43	KMPT	Progress notes	PH16 left a message on Mr J's mother's answerphone re: call back to arrange an appointment for CRHT visit the following day.
10/07/2017	KMPT	Referral	Referral to CRHT for post discharge medication concordance and mental state monitoring. Mr J had been reported to try and give other patients his medication.
11/07/2017 13:29	KMPT	Progress notes	CRHT met with Mr J who reported to feel much better since being home. Mr J reported to be eating healthily at mealtimes and remained focused on his physical fitness. No symptoms of significance reported. History of cannabis use and triggers were in line with what had previously been reported. Mr J was keen to return to work as soon as possible. Agreed to engage with CRHT. PLAN: TLS amber, home visit for 13/07/2017.
11/07/2017 16:00	KMPT	Progress notes	CCO1 met with Mr J who reported he would continue to accept the depot. CCO1 to support Mr J during his OPA next week. Mr J appeared guarded, and paranoid however denied any unusual experiences. Mr J discussed the importance of his diet and water intake. Mr J was looking into volunteer work and alluded he wanted to work away from the local area. Mr J text CCO1 stating he wanted to see the doctor. CCO1 suggested that she met with the doctor after Mr J had seen them at the end of the appointment. The doctor wanted CCO1's input. CCO1 sought feedback from Mr J's mother who reported some paranoid ideation remained and he was preoccupied with his health and heart. Although

Date	Source	Event	Summary
			his diet was the most varied it had been for some time.
12/07/2017	KMPT	Progress notes	STR1 met with Mr J who reported he was still recovering from his admission and wanted to take things slowly. Mr J was guarded and was not forthcoming with positive symptoms that he may be experiencing. STR1 to call Mr J on 26/07/2017.
13/07/2017 09:55	KMPT	Progress notes	CCO1 spoke to Mr J's mother over the telephone. Mr J had been telling his mother he would move to a hotel once he had obtained work so people would not recognise him. Mr J was provided assurances that work was not a priority at present. Mr J had reported that following his psychiatric appointment on 24/07/2017 he would be taken off his medication. Mr J remained guarded and suspicious of supporting services. CCO1 to contact ESA to inform them of discharge.
13/07/2017	GP	Progress notes	Clinic letter dated 07/07/2017 received.
13/07/2017	KMPT	Progress notes	CRHT6 met with Mr J at his home. Mr J reported he was improving with the depot and accepted the depot was better than the tablets. Mr J appeared to have good insight into his mental illness and planned to attend activity groups the following week. Planned visit for 16/07/2017.
14/07/2017	GP	Progress notes	Psychosis review with HMC2. MEDICATION: Aripiprazole 400mg and monthly depot.
16/07/2017	KMPT	Progress notes	CRHT met with Mr J and his mother. Mr J reported he was doing well with no symptoms of concern. Mr J had good insight into his mental illness and was happy to engage with professionals. Agreed for care to be transferred to EIPS. PLAN: discharge from CRHT. Transfer care to EIPS on 17/07/2017. Crisis emergency numbers provided.
18/07/2017	GP	Progress notes	Discharge letter received. Dated 10/07/2017.
21/07/2017	GP	Progress notes	Psychosis review with HMC2.
24/07/2017 16:59	KMPT	Progress notes	Seen by PH1. Mr J admitted under S2 MHA.
24/07/2017	KMPT	Progress notes	Mr J, his mother and CCO1 met with CP2. Diagnosis: psychosis, possibly drug induced. MEDICATION: Aripiprazole Depot injection 400mg every month.

Date	Source	Event	Summary
			There were no reports of concern. Mr J requested to reduce his medication, to stop it or change to tablet form. It was agreed the medication would remain as indicated. PLAN: Medication to remain as previously indicated. CCO1 to continue supporting Mr J. Acute service contact information provided. OPA review to be arranged by CCO1 when necessary.
24/07/2017	GP	Progress notes	Psychosis review with HMC2.
25/07/2017	KMPT	Progress notes	Mr J reported to STR1 that he attended the Charlton and enjoyed himself. Mr J remained preoccupied with his depot and believed he would remain on them for 3 months. Mr J did not associate his improved mental health to the medication during his time in hospital, in fact it was due to being scared of the ward. Mr J stated the medication was poison then said he was sorry and didn't mean to say poison. STR1 was of the opinion that Mr J was still experiencing paranoid ideation. STR1 would look into volunteering at the RSPCA following Mr J's expression of interest.
04/08/2017	KMPT	Progress notes	CCO1 met with Mr J on his birthday. Mr J kept apologising for the kitchen being messy (it was not) and the dog being in the house (CCO1 was not concerned by the dog's presence). Reassurance given. Mr J accepted his depot despite being anxious. EIPS1 agreed to monitor his side effects after reporting the injection made him feel tired and heavy-eyed. Mr J reported he had not attended the fishing activity on Tuesday and helped his sister move home instead. However, following a conversation with Mr J's mother after the appointment, he had informed his mother that he has attended the activity and reported to enjoy it. He did not know where his sister lived. Mr J remained anxious about leaving the home. Mr J's opinion on the amount he was eating did not correspond with his mother's opinion that he was eating very little. Mr J still felt inadequate in comparison with the rest of his family. Mr J permitted CCO1 to discuss his UC and PIP arrangements.
07/08/2017	GP	Progress notes	Identified as unfit for work by GP2.
11/08/2017	KMPT	Progress notes	CCO1 met with Mr J who reported to experience tiredness and blurred vision. Mr J was keen to reduce his depot as he attributes this to his symptoms. Mr J reported to have lost motivation and had low mood "I just feel like telling you to f off". No

Date	Source	Event	Summary
			anger or aggression but irritable although appeared subdued. Mr J 's mother was surprised by his presentation. He had attended a family meal but reported to feel unwell. Mr J's mother would monitor him over the weekend.
14/08/2017	KMPT	Progress notes	CCO1 spoke to Mr J's mother who had reported her son to be low in mood and irritable. He had declined a walk and said, "I was fine before I went into hospital, nothing was wrong". Mr J was of the opinion the depot was making him unwell. He requested the next injection was in his gluteal as the injection in his arm was too close to his heart.
15/08/2017	KMPT	Progress notes	CCO1 spoke with Mr J's mother who reported Mr J did not want to attend the Charlton despite encouragement. Mr J had called his mother stating he did not feel well, and it was too hot. Mr J's mother was concerned about his presentation and his paranoid ideation; he would walk behind his mother so he could step in the way should a car swerve off the road. Concerns about his heart, amount of food intake and diminished self-worth remained. CCO1 shared the concerns about Mr J's lack of improvement. Mr J appeared to have delusional beliefs he was masking in fear of another hospital admission. He had been researching the MHA and not engaged well with services due to his suspicion. CCO1 to arrange a review with CP2.
18/08/2017	KMPT	Progress notes	CCO1 and STR1 met with Mr J. Mr J was pale and continued to complain of fatigue. Mr J disclosed delusional ideation about his heart and stated he had had white mucus in his eyes, he reported his vision was better when he was moving around, or things were close to him. Mr J was worried he was going blind. He had been using a static bike and been able to walk the dog. Mr J also reported dizziness, particularly during the Charlton day. Mr J attributed these to the depot following his research and therefore wanted to reduce his medication. Mr J became irritable and defensive upon recommendation that he had his eyes checked. Mr J was concerned about overeating but no signs of weight gain and appeared underweight. Reduced fluid intake. Advice provided re: recommended fluid intake and the side effects of dehydration fitted his descriptions. Mr J requested CCO1 was not present for his OPA because she "might add to things" and he would feel better with just his mother accompanying him. Mr J became guarded upon gentle questioning and unwilling to engage, he would not consider any activities and attributed his lack of

Date	Source	Event	Summary
			motivation to the side effects of his medication. CCO1 and STR1 had concerns about Mr J's welfare and he appeared threatened by suggestions and observations. Mr J stated he wanted his father as his guardian, CCO1 questioned his contact with his father which Mr J was defensive about and was contradicting his reports when pressed further. Mr J's mother reported her son was more isolative, masking his symptoms and withdrawing from people and trying to lie to cover his concerns. Mr J had been reluctant to leave the house with the exception of going to the pub with the lodger for two hours. She believed Mr J was reported side effects of his medication in order to come off it. CCO1 had arranged an OPA with CP2 for 29/08/2017.STR1 to contact regarding concerns about Mr J's PIP.
23/08/2017	KMPT	Progress notes	EIPS1 contacted Mr J's mother to inform her of their support contact whilst CCO1 was on annual leave. EIPS1 liaised with STR1 who confirmed they would contact Mr J regarding his PIP.
24/08/2017	KMPT	Progress notes	STR1 attempted to contact Mr J a number of times without success. STR1 managed to obtain contact with Mr J's mother. There were no concerns reported and Mr J had managed to leave the house over the weekend to go fruit picking. Mr J contacted STR1 and confirmed he was happy for STR1 to attend his home later that day. Mr J had a drink of water present during the visit and confirmed his PIP appointment on 30/08/2017. Mr J was informed STR1 could not attend. Mr J was happy to attend the appointment alone. STR1 discussed what it meant to have psychotic episodes with Mr J who did not appear to understand why he had the diagnosis or how the EIPS worked. Mr J did not admit to any paranoid or delusional belief, despite STR1 providing examples. STR1 was of the impression Mr J was still experiencing psychotic symptoms and appeared to be losing weight. Mr J attributed his blurred vision to the depot however had been able to use the game console for 40 minutes without issue. When pressed to make appointments for social activities he stated he could not attend them due to blurred visions. PLAN: Try to attend PIP appointment. To meet 04/09/2017 to go to RSPCA for volunteer position.
29/08/2017	KMPT	Progress notes	CCO1 was due to meet Mr J, however his mother cancelled the appointment due to having two other appointments that week and it was felt this would be

Date	Source	Event	Summary
			too much for her son to manage. Mr J's mother reported some improvements; diet and fluid intake, reduced anxiety, and irritability and able to be in more public spaces. However, this was still stipulated by conditions such as limited numbers of people in the car, with his mother driving and the windows up to prevent the air getting in his eyes. Mr J had been reported suicidal ideation which he attributed to the depot, and she remained concerned that his skillset had declined. Mr J was unable to operate the oven and had undercooked his sausages (note: previous occupation). When cutting the grass, he would move around items rather than remove them and had become fixated with some apples that were red, stating they were red from the amount of sun they had and were full of vitamins. The family reported that he had regressed somewhat and had to treat him like a child. His presentation was one that reflected dementia like symptoms with concerns re: cognitive ability. CCO1 spoke with Mr J who requested she collected him for his appointment on 31/08/2017 and agreed for CCO1 to attend his appointment with the consultant psychiatrist. Mr J reported he wished to attend his PIP appointment alone and advice was given should he need further information.
29/08/2017	GP	Progress note	Psychosis review received.
31/08/2017	KMPT	Progress notes	Mr J and CCO1 met with CP2. PLAN: Aripiprazole 400mg injection monthly, advised to see an optician. EIPS to support and monitor his mental health.
31/08/2017	KMPT	Progress notes	STR1 took Mr J home following his appointment. Mr J reported he had arrived too late for his PIP appointment and was not seen. STR1 had planned the journey and time it would take to attend the appointment on time. Mr J reported he left two hours earlier than required and had been left waiting at a train station for nearly an hour and then the satnav took him the wrong way. This was contradictory to previous discussions about how easy he could find it when looking at the map on the appointment letter. STR1's opinion was that Mr J was using avoidance tactics and questioned whether Mr J had left the home. PLAN: STR1 to meet with Mr J 04/09/2017 to go to the RSPCA. STR1 to look into Mr J's PIP assessment.
01/09/2017	KMPT	Progress notes	Retrospective note: CCO1 met with Mr J for his appointment and reported him to appear brighter in

Date	Source	Event	Summary
			his mood and felt less tired. Mr J did not complain of blurred vision. Mr J would like to check the needle prior to the injection as he felt the previous one injected him with air which was the cause of his side effects. Mr J was reminded that there was currently no plan to discontinue his medication after suggesting he only had another two months left. Mr J's report regarding his missed appointment for his PIP appointment was coherent with what was reported to STR1. However, Mr J reported they had not gone through the plan of travel together. Mr J muted the idea of previously being poisoned by cannabis. Mr J became agitated that CCO1 was creating information when she asked if this was during his time in Egypt following a previous conversation she recalled. Mr J criticised CCO1 and his mother stating that they had too much on if they were not retaining and misunderstanding what he was saying. Advise was given that Mr J's mother and CCO1 were recounting what they believed Mr J had said to them and it was possible Mr J had forgotten what he had reported. Mr J was contradictory with his reports. Mr J denied any concerns about his skillset and was upset that his mother had reported this. When Mr J was reminded of his reports that birds and planes were talking to him, Mr J agreed but denied hallucinations. Mr J was concerned about information sharing between his mother and other professionals. A joint meeting would be set up to ensure Mr J was aware of what information was being shared.
04/09/2017	KMPT	Progress notes	STR1 could not take Mr J to the RSPCA due to there being no office, just a contact number. Mr J would like to attend a gardening group each Wednesday. First appointment booked for 13/09/2017.
05/09/2017	KMPT	Progress notes	CCO1 administered Mr J's depot in his gluteal which Mr J was happy with. Mr J was happy to attend the allotment with STR1 next week and would like to participate with the Charlton. Mr J reported he had been walking the dog regularly and had been using his bike. During the visit a "missed appointment letter" arrived for Mr J's PIP appointment. Form competed and Mr J stated he would post the letter.
12/09/2017	KMPT	Progress notes	STR1 completed the referral to the Hub in Tonbridge.
13/09/2017	KMPT	Progress notes	STR1 collected Mr J from his home. Conversation in the car was cohesive and more jointed. Mr J did not appear to have lost more weight. The allotment group had been cancelled without STR1 being informed. Mr J was taken home.

Date	Source	Event	Summary
			PLAN: STR1 to call the group prior to the group and inform Mr J.
15/09/2017	GP	Progress notes	Letter dated 06/09/2017 from Highlands House to GP surgery received.
18/09/2017	KMPT	Progress notes	CCO1 met with Mr J who was reported to be more relaxed, less paranoid, or preoccupied. Mr J was given advice about when he could return to work after suggesting it was EIPS and the medication preventing him from doing so. Mr J's mother remained concerned about some of his behaviour and his lack of cognitive ability; he made mash potato with water and therefore requested his MMSE to be repeated. PLAN: CCO1 to contact GP2 to repeat MMSE.
26/09/2017	KMPT	Progress notes	CCO1 met with Mr J who reported he had been walking the dog, riding his bike, and gardening. Mr J was meeting with the job centre the following week to discuss his benefits. CCO1 advised this would be a good opportunity to discuss returning to work. Advise was given about returning to work whilst under treatment under EIPS. Mr J was of the opinion that CP2 would need to sign this off. Mr J remained unhappy with the depot and was under the impression that he would see a doctor prior to each depot. Advice was given that he would be seen every three to six months. Mr J was keen to stop his medication and became agitated, alluding he didn't want the medication inside him and wanted oral medication. Mr J was advised about the reasons for the depot and the risks of admission if he did not take his medication. Mr J denied the risk and suggested that CCO1 had over-exaggerated his symptoms and information had incorrectly been recorded which resulted in his admission. Mr J had been provided a number to obtain his medical notes but had not acted upon this. Mr J suggested that the service was punishing him and that his symptoms were in relation to the confusion of a breakup. Reassurances were given about people with mental health issues owning their own home and working along with the support that would be required. A timeline of events to be created and a follow up with CP2 to be arranged.
09/10/2017	GP	Progress notes	Letter from Canada House Psychosis Service dated 3/10/2017 received by GP surgery.
12/10/2017	GP	Progress notes	Mr J was given a sick note by GP2.
20/10/2017	GP	Progress notes	Letter from Highlands House dated 17/10/2017 received by GP surgery.

Date	Source	Event	Summary
26/10/2017	GP	Progress notes	GP2 spoke with Mr J's mother who reported an improvement in her son's mental state, despite concerns about his memory. MDT review to take place on 06/11/2017
06/11/2017	KMPT	Progress notes	Mr J did not attend his appointment with STR1. CCO1 chasing.
07/11/2017	KMPT	Progress notes	10:00 CCO1, STR1, EIPS2 were due to meet the previous day with Mr J and his mother. Mr J denied an appointment had been arranged and declined to attend. CCO1 therefore met Mr J at his home. Mr J was declining all interventions with the exception of his depot. Mr J would like to discuss his depot with CP2. Mr J was of the opinion he did not have a mental health disorder and felt able to manage independently without treatment. Mr J's mother remained concerned about her son's mental health and his cognitive ability. There were concerns that his reluctance to engage could result in further relapse and would therefore remain in contact with EIPS regarding her son. Mr J's mental state had stabilised although continued to experience symptoms and lacked insight.
07/11/2017	KMPT	Progress notes	17:00 Mr J had reported to CCO1 that he had been walking the dog and using the static bike, although did not report that he had been working with his mum. Mr J would like to start work in January. Mr J's mother stated that he had met with his father who had recommended watching 'one flew over the cuckoo's nest' and that Mr J could not be forced to have his depot injection. Appointment arranged for December. Mr J to meet with CP2 to discuss medication.
07/11/2017	KMPT	Progress notes	17:43 STR1 had arranged an appointment with Mr J for 12/12/2017. Appointment letter sent.
09/11/2017	KMPT	Progress notes	CMHT referral closed due to ongoing support from EIPS.
17/11/2017	KMPT	Progress notes	OPA rearranged for January 2018. Mr J accepting of this. Depot booked for December 2017.

Date	Source	Event	Summary
01/12/2017	KMPT	Progress notes	Mr J's mother reported to CCO1 that there had been no change in her son's presentation, and he continued to request to come off his depot. Mr J's mother would call CCO1 after she had seen him over the weekend.
04/12/2017	GP	Progress notes	Mr J's mother contact GP2 and requested an assessment for Mr J.
08/12/2017	GP	Progress notes	Psychosis review GP2. Mr J reported significant improvements in his mental health, paranoid thoughts, visual and auditory hallucinations not present. Good engagement. Reported good self-care. Request oral medication as he did not like the depot injection. Oral treatment to be discussed. Referral to "mental health worker".
11/12/2017	KMPT	Progress notes	CCO1 met with Mr J at his home. He was reported to be relaxed and engaged well with no irritability. Mr J would like to stop his depot in favour of oral medication, it was agreed this would be discussed with CP2 in January 2018. Mr J would like to consider returning to work in the new year, CCO1 advised they could support this.
11/12/2017	GP	Progress notes	Psychosis review HMC2. Mr J drinking one unit of alcohol per week.
05/01/2018	KMPT	Progress notes	CCO1 received a letter from GP2 informing her that Mr J's MMSE scored 29/30 in comparison to 19/30 12 months previous. Markedly improved in his presentation and Mr J was keen to return to oral medication. CCO1 contacted Mr J's mother who reported significant change over the Christmas period with intake of various foods and drink, was more relaxed and had gained weight. Mr J had bought gifts for his siblings and had arranged a date on New Year's Eve, which he reported she cancelled nearer the time. Mr J had reconnected with old friends and was leaving the house and eating without anxiety. Mr J reported to his mother that he was bored which was deemed positive as EIPS could support Mr J back into work. Mr J was nervous about meeting the new consultant and was desperate to come off the depot. CCO1 confirmed she supported Mr J's request to move to oral medication.
09/01/2018	GP	Progress notes	Psychosis review. Mr J was issued with a sick note, not fit for work.

Date	Source	Event	Summary
16/01/2018 17:23	KMPT	Progress notes	CCO1, and EIPS3 met with Mr J to give him his depot injection. No concerns. Mr J was willing to start working. Advice about where he could go for support was provided as he was unwilling to accept help at the time.
16/01/2018 18:00	KMPT	Progress notes	Addition to previous entry: Mr J presented with much improved self-care and had gained weight. Reduced anxiety and appeared more relaxed. Mr J would consider working for his mother and was happy to attend his appointment with CP3.
25/01/2018	GP	Progress notes	Psychosis review.
29/01/2018	KMPT	Progress notes	CP3, CCO1 met with Mr J and his mother. Good progress had been made since Mr J's discharge from hospital. Mr J would like to get back into being a dessert chef and return to oral medication. Risks of relapse within the first 6-12 months were discussed. No risks indicated in Mr J's mental state examination. MEDICATION: Aripiprazole 400mg depot injection monthly. PLAN: CP3 provided Mr J with a prescription for 28 days. Oral aripiprazole starting at 20mg daily (14 days) increasing to 30mg daily thereafter. Clonazepam 0.5mg daily PRN (seven tablets). GP2 to continue to prescribe aripiprazole 30mg daily until further notice. Mr J to continue the aripiprazole injection as of that day. CCO1 to rebook an appointment if required. RISKS: risk of relapse into psychosis, risk of self-neglect. No risk to others.
01/02/2018	GP	Progress notes	Psychosis review with HMC1. Aripiprazole 30 mg one tablet per day. 28 tablets.
02/02/2018	KMPT	Progress notes	CCO1 met with Mr J at his home address. He had received his Universal Credit questionnaire which they completed together. Mr J allowed CCO1 to complete sections of his form, particularly those around his anxiety. Mr J reported he was pleased with the outcome his appointment with CP3 and was keen to consider the 12-week work placement. CCO1 to refer Mr J for this.
14/02/2018	KMPT	Progress notes	VR1 was unable to contact Mr J or leave a message.

Date	Source	Event	Summary
15/02/2018	KMPT	Progress notes	VR1 contacted Mr J, phone unavailable. Contact to be attempted on 19/02/2018 and letter sent if no response.
19/02/2018	KMPT	Progress notes	WR1 contacted Mr J and provided an overview of the services and the job taster programme. Mr J would like warehouse work which was not something VR1 could offer as a job taster however could support the application process and possibly look into a warehouse placement. Mr J was unsure if this would be useful. Agreed that his appointment could be cancelled or changed if needed nearer to the time. PLAN: First appointment 8/03/2018 at 12pm.
23/02/2018	KMPT	Progress notes	VR1 received a text message from Mr J requesting his appointment was cancelled. Mr J apologised and thanked VR1. VR1 informed CCO1 who would liaise with Mr J before VR1 discharged him.
13/03/2018	KMPT	Progress notes	CCO1 liaised with Mr J's mother who reported her son was doing well and currently had a girlfriend. She was supportive of Mr J and seemed happy together. Mr J was applying for warehouse work and was showing good insight, humour, and self-care. Mr J was compliant with his medication.
19/03/2018	KMPT	Progress notes	CCO1 met with Mr J at his home. There were no concerns and Mr J reported he had a girlfriend. Mr J continued to seek employment but was yet to be successful and was reluctant to join an agency at the time. Job seeking advice provided by CCO1. Mr J was not keen to complete taster work with other service users and would be interested in an opportunity to work with no patient contact. CCO1 would contact VR1 to advise her of this. Mr J reported some anxiety around starting work. Mr J was compliant with his medication and pleased to have stopped his depot. Agreed to see Mr J in one month.
23/04/2018	KMPT	Progress notes	EIS3 advised VR1 that Mr J did not require vocational support and was therefore discharged.
18/05/2018	KMPT	Progress notes	CCO1 contacted Mr J's mother advising she would be on annual leave and would make contact upon her return.

Date	Source	Event	Summary
24/05/2018	KMPT	Progress notes	11:49 CCO1 made contact with Mr J via text, he reported to be well and was currently in his first week of induction and therefore could not talk. Mr J's mother reported that Mr J had been using cannabis, it was evident his girlfriend was using, and Mr J therefore restarted. Mr J had presented under the influence a couple of occasions, his mother had confronted him and stated he would have to move out if this continued. His girlfriend was also banned from the house. Mr J's mother was angry and upset that he had allowed himself to get involved with drugs again. There were concerns about medication compliance and his mother was going to contact his GP to identify if his scripts had been collected. Mr J's car had also been written off by a drunk driver.
24/05/2018	KMPT	Progress notes	GP confirmed that Mr J last collected his prescription on 15/05/2018.
04/06/2018	KMPT	Progress notes	CCO1 met with Mr J at home. Mr J was relaxed and reported he had been successful with a job at a supermarket, working daily short shifts but is also getting regular overtime. Mr J reported he was enjoying the job and also went on a works night out. He was accompanied by his brother and were out until 6am. There were no reports of anxiety or paranoia. He reported he had ended his relationship with his girlfriend and was content about this. Mr J advised he was managing independently, was compliant with his medication with no side effects. CCO1 was informed of the incident about his car and Mr J seemed to have dealt with the situation well. Mr J did not request additional support and agreed to meet in one month. CPA review: No current drug use detected following mother's concern about use with his girlfriend. Obtain a job and was happy. Socialising more and compliant with medication. No concerns raised.
27/06/2018	KMPT	Progress notes	Note for previous day. CCO1 spoke with Mr J's mother following her visit. She believed Mr J was masking his symptoms and agreeing with staff to enable an early discharge. Mr J remained upset with CCO1 for referring him to the crisis team. Mr J requested that information recorded about his symptoms was removed due to believing it was never reported. CCO1 advised this could not be done however could record that it was disputed by Mr J. Mr J reluctantly agreed for CCO1 to attend the next ward round.

Date	Source	Event	Summary
			CCO1 received a text apologising he had been forgetting his medication. CCO1 responded focusing on Mr J's recovery. Mr J's mother sent photos to CCO1 of water Mr J had stored in the freezer and underneath his bed. She reported she found it difficult to speak up when Mr J was there in case anything to the contrary and he became upset with her. CCO1 reassured staff were aware of Mr J's guarded behaviour.
16/07/2018	KMPT	Progress notes	Mr J's mother contacted CCO1 with concerns about her son's presentation. Mr J had lost his job but could not ascertain why. Mr J had obtained a labouring job which seemed to be going well however Mr J had become guarded and irritable. Upon arrival, CCO1 was welcomed by Mr J who was fairly relaxed. Mr J did not seem distressed by the loss of his job, nor did he report any events leading up to his end in contract. Mr J reported a little anxiety around his new job due to the relationships and people asking him to do different things. CCO1 provided some distraction techniques to prevent ruminating when trying to sleep. Mr J stated he needed to walk the dogs now in order to get to bed for 6pm, implying CCO1 was delaying him. He reported it was taking three hours to get to sleep. CCO1 suggested a later bedtime and possibly his body and mind were not ready for an early bedtime, Mr J became irritated stating it was his decision when he went to bed. His presentation of dark circles under his eyes was similar to when he was unwell. Mr J agreed to monitor his sleep, in case it worsened and other relapse symptoms occurred. CCO1 was informed he was taking his medication and also visited his father. Upon questioning Mr J became agitated which was also a presentation previously. Mr J's mother reported her son had been giving different stories to members of the family, stating he had gone to Camber with his ex but informed his mother he was with his Dad. No other symptoms. CCO1 stated she would contact Mr J's mother the following day as the conversation was cut short.
22/08/2018	KMPT	Progress notes	Text conversation with Mr J arranging his next appointment. Mr J informed CCO1 that he had changed jobs after leaving his last for another that had ended quickly. His new job was due to start the following week. No concerns raised. Mr J's mother was abroad (for work purposes).[32]

[32] Mr J's mother provided this context to the investigation team

Date	Source	Event	Summary
05/09/2018	KMPT	Progress notes	CCO1 spoke to Mr J over the telephone whilst he was working as a labourer which he believed would continue until November. Mr J would seek indoor work once this contract completed. Mr J reported to feel well and had no concerns about his mood, diet, or anxiety. Compliant with his medication and admitted to not doing much more outside of working other than gaming. Mr J declined talking therapy and felt he no longer needed EIPS support but agreed for CCO1 to refer for OPA. No concerns raised and would meet in October.
10/09/2018	KMPT	Progress notes	Mr J's mother text CCO1 with concerns about her son stating he had called her asking if he would get in trouble for eating too much. Mr J also had concerns about his hair falling out and had a migraine. CCO1 planned to meet Mr J the following day however he stated he was unavailable. Agreed for a telephone call to take place.
13/09/2018 18:36	KMPT	Progress notes	CCO1 left a message on Mr J's answerphone stating she was on leave until 25/09/2018 and would contact him upon her return. Mr J's mother was provided the duty number.
13/09/2018 19:04	KMPT	Progress notes	CCO1 spoke to Mr J over the phone. Mr J was engaging in conversation and reported no concerns. Reported to be eating well.
29/09/2018	KMPT	Progress notes	Mr J was arrested for the alleged murder of his neighbour and her daughter and the attempted murder of her husband. Known to West EIPS. Mr J was under constant supervision for forensic purposes rather than concerns about risk to self. Advised Mr J that they were awaiting samples from the crime scene investigators before he was interviewed, to be completed by a psychiatrist. Mr J had taken his medication and script checked. Limited information given concerning Mr J's risks and history. Advised re: FOI request should they require additional information. Very little in his record that appeared relevant or significant to enquiries. PLAN: Await assessment by psychiatrist. Referral to prison mental health services if charged. Referral to forensic services.
02/10/2018	KMPT	Progress notes	Retrospective note for 27/09/2017. STR1 collected Mr J to take him to the allotment. Mr J was asking unusual questions upon arrival about who would be there and if they were allowed on the allotment. ESI2 was of the opinion that Mr J was stigmatised by his experience of his psychosis and did not want to be with others experiencing

Date	Source	Event	Summary
			mental health problems. After the facilitator outlined the purpose of the day, Mr J was not keen on the group nor was it what he expected it to be and thought it would be a Charlton event. Mr J requested he went home. Mr J reported on the way home that he did not need social activities as he was due to start work the following week. When asked what the job was, he stated he did not have one yet but was meeting with the job centre. When asked why he thought he would be working immediately, he stated he would just get a job there and then. STR1 advised about the process of job appointments but Mr J seemed to think he would be recruited in one-day; evidence of thought problems. STR1 offered to support Mr J with his appointment should he want it. PLAN: STR1 to contact CCO1 due to Mr J's lack of engagement and avoiding activities. STR1 of the opinion Mr J was experiencing strange beliefs and having cognitive issues. Mr J to contact STR1 regarding the appointment with the job centre. STR1 to contact Mr J on 09/10/2017 if Mr J had not done so already.

Appendix E Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
The regulation applies to registered persons when they are carrying on a regulated activity.

CQC can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section of this guidance for more detail.
The regulation in full
20.—

1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.
2. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—
    a. notify the relevant person that the incident has occurred in accordance with paragraph (3), and
    b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification.
3. The notification to be given under paragraph (2)(a) must—
    a. be given in person by one or more representatives of the registered person,
    b. provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,
    c. advise the relevant person what further enquiries into the incident the registered person believes are appropriate,
    d. include an apology, and
    e. be recorded in a written record which is kept securely by the registered person.
4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—
    a. the information provided under paragraph (3)(b),
    b. details of any enquiries to be undertaken in accordance with paragraph (3)(c),
    c. the results of any further enquiries into the incident, and
    d. an apology.
5. But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —
    a. paragraphs (2) to (4) are not to apply, and
    b. a written record is to be kept of attempts to contact or to speak to the relevant person.

6. The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).
7. In this regulation—
   "apology" means an expression of sorrow or regret in respect of a notifiable safety incident; "moderate harm" means—
   a. harm that requires a moderate increase in treatment, and
   b. significant, but not permanent, harm;
      "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
      "notifiable safety incident" has the meaning given in paragraphs (8) and (9);
      "prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
      "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
      "relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—
   c. on the death of the service user,
   d. where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
   e. where the service user is 16 or over and lacks capacity in relation to the matter;
      "severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.
8. In relation to a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—
   a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
   b. severe harm, moderate harm or prolonged psychological harm to the service user.
9. In relation to any other registered person, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—
   a. appears to have resulted in—
      i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,
      ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,

iii. changes to the structure of the service user's body,
iv. the service user experiencing prolonged pain or prolonged psychological harm, or
v. the shortening of the life expectancy of the service user; or

b. requires treatment by a health care professional in order to prevent—
i. the death of the service user, or
ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

Appendix F NIAF: Internal investigation report

Rating	Description	Number
	Standards met	**22**
	Standards partially met	**2**
	Standards not met	**1**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The report identifies that it is a comprehensive root cause analysis investigation report. The Trust Serious Incident Policy (v4.1) identifies that a serious incident investigation undertaken by trained investigators is required.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The terms of reference include the scope and type of investigation and what is to be investigated. All are appropriate.	
1.3	The person leading the investigation has skills and training in investigations	The investigation was led by a member of staff who had received a two-day RCA training package. Support was provided by an external consultant psychiatrist who had received a one-day RCA training package.	
1.4	Investigations are completed within 60 working days	The incident occurred on 29 September 2018 and the investigation report date is 8 March 2019. This is beyond 60 working days, and although this is not uncommon for investigations where there is an associated complex criminal investigation, there is no explanation in the report of whether there was an extension or 'stop the clock' agreed.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is written in plain English without typographical errors.	
1.6	Staff have been supported following the incident	The report states that support was provided to the care coordinator by an Assistant Director and Head of Nursing, and that a clinical psychologist provided a debrief to the early intervention team	

Standard		Niche commentary	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident.	
2.2	The terms of reference for the investigation should be included	The terms of reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people	The report describes that the internal investigation team met with relevant staff, reviewed organisational clinical records, and referenced Trust policies and national guidance. Contributory factors are set out in detail.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	The report provides details of the support that Mr J's mother and sister received from the investigators, an Assistant Director, and the Medical Director.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	The report states that Mr J's mother and sister contributed to the terms of reference for the internal investigation.	
2.6	A summary of the patient's relevant history and the process of care should be included	A summary of Mr J's relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included	A chronology of Mr J's care was included.	
2.8	The report describes how RCA tools have been used to arrive at the findings	The report explains in detail how the RCA analysis was conducted.	
2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	No care and service delivery problems are explicitly identified, but different factors (for example task factors, communication factors, organisational factors) are identified in detail.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification	Contributory factors are identified.	

Standard		Niche commentary	
	frameworks, examination of human factors)		
2.11	Root cause or root causes are described	The root causes section provides a narrative of consideration of predictability and preventability. It also identifies two key points in time that "if managed differently, may have had an impact on the outcome".	
2.12	Lessons learned are described	Problems are identified that both contributed to the outcome and that did not contribute to the outcome.	
2.13	There should be no obvious areas of incongruence	There are no areas of incongruence.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The way in which the terms of reference have been met is set out clearly.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues	The terms of reference covered the right issues.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report considers what factors contributed to poor care and missed opportunities, but these are not directly linked with how a recurrence might be prevented.	
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	Six recommendations were made, all relate to the findings.	
3.4	Recommendations are written in full, so they can be read alone	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome focussed	Recommendations are measurable and outcome focussed.	

Appendix G Definition of the term 'root cause'

The term root cause has been referred to since as early as 1905, where the root cause of a problem with health care in the Rhondda Valley was reported in the Lancet. [33]

Over the years since, the term root cause has been used in investigation methodology, where safety investigations have been conducted using root cause analysis principles.

Thinking has developed to move around from simply identifying the root cause as the most basic causal factor to one that, if changed, would have changed the outcome.

The purpose of carrying out root cause analysis investigations is to make improvements so that the chance of error is reduced or removed. In order to do this one cannot simply look for the most basic causal factor but look for the most basic causal factor which could be corrected.

As a result, root cause analysis methodology now refers to the root cause being the most basic/earliest causal factor which is **amenable to management intervention**. There are numerous examples of this available in generic root cause analysis guidance, for example:

In the 2008 TapRooT® Book, we changed the definition of root cause to:

"A Root Cause is the absence of a best practice or the failure to apply knowledge that would have prevented the problem."

The 2008 TapRooT® Book is available at this link:
http://www.taproot.com/store/Books/

A root cause is the deepest cause in a causal chain that can be resolved. If the deepest cause in a causal chain cannot be resolved, it's not a real problem. It's the way things are. http://www.thwink.org/sustain/glossary/RootCause.htm

The most useful definition identified to date is the definition used by Paradies and Busch (1988), that is: the most basic cause that can be reasonably identified and that management has control to fix.

"A root cause is the most basic causal factor or factors which, if corrected or removed, will prevent recurrence of a situation" writes John Robert Dew, EdD, in an article published in the proceedings of the 56th Annual Quality Congress in 2002.

"There is honest disagreement as to whether or not an error can be attributed to a single root cause ... or whether there will be a cluster of causes" Dew adds.

[33] The Present State of Medical Practice in the Rhondda Valley". The Lancet.18 November 1905

Dew presents five basic root causes:

1. Putting budget before quality.
2. Putting schedules before quality.
3. Putting politics before quality.
4. Arrogance.
5. Lack of understanding of knowledge, research, and education.

Applying safety methodology to healthcare was accepted by the National Patient Safety Agency. The National Patient Safety Agency Root cause analysis training tools and guidance refer to the root cause as follows:

> "A fundamental contributory factor. One which had the greatest impact on the system failure.
>
> One which, if resolved, will minimise the likelihood of recurrence both locally and across the organisation."

Some of the anxieties that are experienced about identifying a factor as a root cause stem from our continued problem with approaching investigations in order to learn. The purpose of root cause analysis is to learn what caused something bad to happen and how to stop it from happening in the future. It is predicated on systems theory and should not be used to identify individual culpability.

However, with the increasing chance of litigation it is increasingly difficult for organisations to simply identify learning from an investigation.

In 2016 the American National Patient Safety Forum recommended a new approach to root cause analysis that makes the purpose of the investigation process much clearer.

They have produced guidance on the subject, and they have renamed root cause analysis as RCA². In the guidance pack they make the following statement:

"The actions of an RCA² must concentrate on systems-level type causations and contributing factors. If the greatest benefit to patients is to be realized, the resulting corrective actions that address these systems-level issues must not result in individual blaming or punitive actions. The determination of individual culpability is not the function of a patient safety system and lies elsewhere in an organization."

In addition, the following is included:

Why Is "Human Error" Not an Acceptable Root Cause?

While it may be true that a human error was involved in an adverse event, the very occurrence of a human error implies that it can happen again. Human error is inevitable. If one well-intentioned, well-trained provider working in his or her typical environment makes an error, there are system factors that facilitated the error. It is critical that we gain an understanding of those system factors so that we can find ways to remove them or mitigate their effects.

Our goal is to increase safety in the long term and not allow a similar event to occur. When the involved provider is disciplined, counseled, or re-trained, we may reduce the likelihood that the event will recur with that provider, but we don't address the probability that the event will occur with other providers in similar circumstances. Wider training is also not an effective solution; there is always turnover, and a high-profile event today may be forgotten in the future. This is reflected in Figure 3, the Action Hierarchy, which is based upon safety engineering principles used for over 50 years in safety-critical industries. Solutions that address human error directly (such as remediation, training, and implementation of policies) are all weaker solutions. Solutions that address the system (such as physical plant or device changes and process changes) are much stronger. This is why it's so important to understand the system factors facilitating human error and to develop system solutions.

Review teams should not censor themselves when it comes to identifying corrective actions. This is important because the team's job is to identify and recommend the most effective actions they can think of, and it is leadership's responsibility to decide if the benefit likely to be realized is worth the investment, in light of the opportunity cost and its impact on the system in general. Only the top leadership of an organization can accept risk for the organization, and this is a responsibility that should not be delegated to others. ◆

The term root cause in a systems/root cause analysis investigation remains as identified by the National patient safety agency (England):

"The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence."

Appendix H NIAF: Action plan progress

Our measurement criteria:

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

Recommendations made by the Trust	
1	All Early Intervention for Psychosis (EIP) staff to be able to undertake a robust mental state examination including using the Positive and Negative Syndrome Scale (PANSS) and be able to develop a relapse prevention plan for each client on their caseload.
2	All EIP staff to be aware of and actively implement procedures outlined in the EIP Operational Policy following its launch in March 2019.
3	The EIP Operational Policy needs to contain clear guidance for managing difficult to engage / non-engaging service users, including clarity regarding clients that are being managed at arm's length, including frequency of face-to-face contact.
4	The EIP team to monitor the risk status and management plans of those individuals whose mental state appears to be deteriorating via a Red Board meeting three times per week. Clarity needed regarding the RAG ratings, criteria for each category and what to do and when to do it
5	To ensure that all carers are actively involved in EIP throughout the three years the service user is cared for by the service

Recommendations made by the Trust	
6	For there to be dedicated and consistent medical cover available in all areas that EIP provide a service.

Rec	Action progress cited by Trust	Niche comment and assessment
1	The Trust provided PANSS training on 23 May 2019 with the expectation that PANSS will be completed for all patients accepted onto the caseload of the Early Intervention in Psychosis teams. Following training it was agreed that all staff would complete PANSS for new patients and that for existing patients, staff would complete PANSS two weeks prior to each Care Programme Approach review. An audit to be completed by 30 September 2019 of ten new cases for the East team, and ten new cases for the North/West team. New staff to be trained by existing Early Intervention in Psychosis staff. It was agreed by the patient safety team and senior management of Early Intervention in Psychosis teams that the action would remain open until a further audit had been conducted in January 2020. On 5 December 2019 it was agreed with senior Early Intervention in Psychosis leads that PANSS would not be used as an outcome measure and would only be used for new assessments. Therefore, although a PANSS audit would still be conducted in January 2020 this would measure new referrals from 1 June 2019 with a PANSS assessment. On 2 December 2019 there were 47.5% of new referrals with a PANSS completed.	The audit for the East was conducted in October 2019 and covered 25 patients. The audit showed that only 11 patients (44%) had a PANSS completed. Four of these 11 patients' PANSS had been completed in more than 13 months prior to the audit. The audit for the West and North was conducted in October 2019 and covered 25 patients. The audit showed that only two patients (8%) had a PANSS completed. One of these two patients' PANSS had been completed in June 2018, 15 months prior to the audit. The new Early Intervention in Psychosis policy produced in March 2019 states that PANSS should be updated at each Care Programme Approach review, undertaken every six months for Early Intervention in Psychosis patients. The decision taken in December 2019 by senior Early Intervention in Psychosis leads contradicts the revised policy. It is now unclear what approach the Trust is taking to ensure that staff are able to undertake a robust mental state examination to inform the development of a relapse plan, particularly when patients' risks or presentation changes. A list of care coordinators was also provided, indicating whether they had completed the PANSS training. This shows that from a total of 50 care coordinators, 38 (76%) had completed training. We note that one of the 12 care coordinators who had not completed the training was Mr J's care coordinator. It is not clear from the information provided how many of the 12 care coordinators who had not completed the training were new staff.

Rec	Action progress cited by Trust	Niche comment and assessment	
		Although the Trust has tested the effectiveness of the action, our analysis shows that not all Early Intervention in Psychosis staff have been trained in PANSS training and the Trust audit found that only 47% of newly referred patients had a PANSS completed. In addition, staff were no longer expected to act in accordance with the new policy in completing a PANSS assessment every six months, prior to a patient's Care Programme Approach review. NIAF rating: 2 (action significantly progressed)	
2	The Trust launched a revised Early Intervention in Psychosis policy on 2 May 2019. Evidence that the operational policy was discussed at the business meeting, Early Intervention in Psychosis managers meeting and locality meetings to embed the policy. CLiQ checks were completed for each locality, initially every two weeks and then reduced to monthly due to a "vast improvement in quality". The Trust was arranging an external audit into the Early Intervention in Psychosis service. However, in the interim a deep dive would be completed by the end of February 2020 by Crisis Resolution and Home Treatment managers. It was agreed in January 2020 that the Trust auditors would undertake an external audit for Early Intervention in Psychosis using the template developed by the Trust Quality Lead. This was planned for February 2020.	At the Early Intervention in Psychosis managers' meeting held on 25 March 2019 it was documented that there was concern that several clinicians had not had PANSS training. However, it was also documented that PANSS assessments were not being included in CLiQ checks until the end of September 2019. The CLiQ check dated 18 November 2019 for the South West team covered a review of 68 case notes. An email dated 18 November 2019 from the Clinical Quality Manager highlighted a concern of no improvement over the previous three months. It was acknowledged in that email that there were a number of clinicians that were new to the team and a request was made for a discussion about how the team could be supported to make the necessary improvements. We have not seen any evidence to indicate any improvement in the CLiQ checks. There is now one manager covering South West Kent and Maidstone, and a formal consultation is in place to move to a central base in West Kent. The Trust has stated this will ensure improved and consistent evidence of quality. The Trust has reported that external audits have been conducted in three of the six localities for Early Intervention in Psychosis. Although the Trust has cited that the feedback was positive, we have not seen evidence of this.	

Rec	Action progress cited by Trust	Niche comment and assessment	
		We have not seen evidence that all staff are aware of and are actively implementing procedure outlined in the new Early Intervention in Psychosis Operational Policy launched in March 2019. NIAF rating: 2 (action significantly progressed).	
3	The operational policy provides clear guidance for managing difficult to engage / non-engaging patients. The revised policy was authorised in March 2019, distributed in April 2019, and was due for review in November 2019.	There is evidence of discussion about the new policy at business meetings. The new policy provides clear guidance on which RAG category a patient should be rated if they are starting to disengage, or who are not engaging. The policy also provides clear guidance on the frequency patients in the different RAG categories should be discussed and what forum should be used (i.e., Red Board meetings, or staff supervision). NIAF rating: 4 (action complete, tested, and embedded).	
4	Risks and management plans are monitored through regular CLiQ checks. A separate audit was also completed checking the progress notes of patients on the Red Board. Patients in the Red category should be discussed three times per week. Staff have signed a form "to provide assurance" that they are aware of and understand the standards. Staff have been given the opportunity to have further guidance if required. RAG rating is discussed in supervision to ensure that patients are seen in accordance with the RAG standards. If this has not occurred, reasons are discussed, and a plan developed. Red Board meetings are held three times per week and a RAG rating spreadsheet is saved at each meeting.	We can see that an audit was completed for Red Board meetings held in May 2019, this included a random sample of patients who were discussed during this month. The Trust reported that of the ten patients included in the audit, all were discussed at the Red Board meeting, there was a management plan documented in their clinical records and there was evidence that actions had been completed. We have not seen any other audit data that would enable us to state that the Trust is able to demonstrate a sustained improvement. NIAF rating: 4 (action complete, tested, and embedded).	

Rec	Action progress cited by Trust	Niche comment and assessment	
5	Carers are identified when a new patient is accepted onto the caseload of an Early Intervention in Psychosis team. Staff use a checklist to ensure that appropriate information is sent to carers / families. A carers education programme was being developed, and a pilot programme being implemented in the North locality. Training is provided to new staff and as a refresher to existing staff. Family involvement training within the Early Intervention in Psychosis teams is required.	A carers audit was conducted on 1 November 2019. This showed that: • East, of five patient records reviewed there was evidence of only one carers pack having been sent out, and discussion with a carer about support and assessment in another case. • West, of five patient records reviewed there was evidence of only one carers pack having been sent out. The Trust documented that actions were taken by a manager to address the audit results, but we have not been provided with details of these. The Trust has also documented that the service manager had checked the process with the admin team who reported that carers packs do get sent out and it was likely to be a recording issue. We have not seen any other evidence indicating that this issue has been resolved and therefore we are unable to say that the action is complete. NIAF rating: 2 (action significantly progressed).	
6	Two members of staff had completed non-medical prescribing qualifications and business cases were being developed for funding for two posts within Early Intervention in Psychosis teams to support medical staff. Consultant posts are dedicated to Early Intervention in Psychosis teams and only have alternative cover when urgent face-to-face appointments need to be covered during periods of consultant leave. Issues in West Kent due to lack of capacity for one consultant who had a third more on caseload (313) than East Kent (216). Waiting times for a medical appointment as of 3 December 2019 were:	The Trust has taken action to attempt to address the issue of access to medical appointments, but the evidence provided indicates that the actions have not resolved the issue. NIAF rating: 1 (action commenced).	

Rec	Action progress cited by Trust	Niche comment and assessment	
	East: A&S 20 days for urgent, 8 weeks for non-urgent; C&C 14 days for urgent, 9 weeks for non-urgent; TDD 3 days for urgent, 7 weeks for non-urgent. West: 10 days for urgent, DGS 8 weeks for non-urgent; Medway & Maidstone/SW Kent 16 weeks for non-urgent. SW Kent medical budget to fund a specialty doctor to cover North and West. Agency cover agreed whilst recruitment to substantive post taking place.		

Appendix I NICE guidance psychosis and schizophrenia in adults: prevention and management – clinical guideline (CG178)

Standards	Available to Mr J
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	Yes. Good evidence of working in partnership with Mr J's mother and intensive contact with Mr J when he was at his most unwell.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	Yes, evidence of input from a Support Time and Recovery Worker to encourage physical activity.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes.	Concerns expressed by Mr J and his mother about his weight responded to appropriately.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	Mr J reported that he had stopped smoking in 2015.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Mr J expressed numerous concerns about his weight, and these were followed up by his care coordinator.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	No evidence during period under review.
Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own	Staff provided support to Mr J's mother and

Standards	Available to Mr J
needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	arranged for a carer's pack to be sent to her.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	No evidence.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	Carer's pack provided.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Good evidence throughout period reviewed.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Yes.
Offer a carer-focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should: be available as needed, have a positive message about recovery.	No evidence.
Include carers in decision-making if the service user agrees.	Yes.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	No evidence.
First episode psychosis standards **Early intervention in psychosis services**	
Early intervention in psychosis services should be accessible to all people with a first episode or first presentation of psychosis, irrespective of the person's age or the duration of untreated psychosis.	Yes.

Standards	Available to Mr J
People presenting to early intervention in psychosis services should be assessed without delay. If the service cannot provide urgent intervention for people in a crisis, refer the person to a crisis resolution and home treatment team (with support from early intervention in psychosis services). Referral may be from primary or secondary care (including other community services) or a self- or carer-referral.	Yes.
Early intervention in psychosis services should aim to provide a full range of pharmacological, psychological, social, occupational, and educational interventions for people with psychosis, consistent with this guideline.	Yes.
Consider extending the availability of early intervention in psychosis services beyond 3 years if the person has not made a stable recovery from psychosis or schizophrenia.	Not applicable.
Primary care	
Do not start antipsychotic medication for a first presentation of sustained psychotic symptoms in primary care unless it is done in consultation with a consultant psychiatrist	Yes.
Assessment and care planning	
Carry out a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. The assessment should address the following domains: • psychiatric (mental health problems, risk of harm to self or others, alcohol consumption and prescribed and non-prescribed drug history) • medical, including medical history and full physical examination to identify physical illness (including organic brain disorders) and prescribed drug treatments that may result in psychosis • physical health and wellbeing (including weight, smoking, nutrition, physical activity and sexual health) • psychological and psychosocial, including social networks, relationships and history of trauma • developmental (social, cognitive and motor development and skills, including coexisting neurodevelopmental conditions) • social (accommodation, culture and ethnicity, leisure activities and recreation, and responsibilities for children or as a carer) • occupational and educational (attendance at college, educational attainment, employment, and activities of daily living) • quality of life • economic status.	Yes.

Standards	Available to Mr J
Assess for post-traumatic stress disorder and other reactions to trauma because people with psychosis or schizophrenia are likely to have experienced previous adverse events or trauma associated with the development of the psychosis or as a result of the psychosis itself. For people who show signs of post-traumatic stress, follow the recommendations in the NICE guideline on post-traumatic stress disorder.	Traumatic events discussed by Mr J prior to the period under review. No evidence these were considered in the context of post-traumatic stress disorder.
Routinely monitor for other coexisting conditions, including depression, anxiety, and substance misuse particularly in the early phases of treatment.	Yes.
Write a care plan in collaboration with the service user as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. Send a copy of the care plan to the primary healthcare professional who made the referral and the service user.	Yes.
For people who are unable to attend mainstream education, training or work, facilitate alternative educational or occupational activities according to their individual needs and capacity to engage with such activities, with an ultimate goal of returning to mainstream education, training or employment.	Yes.
Treatment options	
For people with first episode psychosis offer: • oral antipsychotic medication (see sections 1.3.5 and 1.3.6) in conjunction with • psychological interventions (family intervention and individual CBT, delivered as described in section 1.3.7).	Yes.
Advise people who want to try psychological interventions alone that these are more effective when delivered in conjunction with antipsychotic medication. If the person still wants to try psychological interventions alone: • offer family intervention and CBT • agree a time (1 month or less) to review treatment options, including introducing antipsychotic medication • continue to monitor symptoms, distress, impairment, and level of functioning (including education, training, and employment) regularly.	Not applicable.
If the person's symptoms and behaviour suggest an affective psychosis or disorder, including bipolar disorder and unipolar psychotic depression, follow the recommendations in the NICE guidelines on bipolar disorder or depression.	Not applicable.
Choice of antipsychotic medication	
The choice of antipsychotic medication should be made by the service user and healthcare professional together, taking into account the views of the carer if the service user agrees.	Yes.

Standards	Available to Mr J
Provide information and discuss the likely benefits and possible side effects of each drug, including: • metabolic (including weight gain and diabetes) • extrapyramidal (including akathisia, dyskinesia, and dystonia) • cardiovascular (including prolonging the QT interval) • hormonal (including increasing plasma prolactin) • other (including unpleasant subjective experiences).	
How to use antipsychotic medication	
Before starting antipsychotic medication, undertake and record the following baseline investigations: • weight (plotted on a chart) • waist circumference • pulse and blood pressure • fasting blood glucose, glycosylated haemoglobin (HbA1c), blood lipid profile and prolactin levels • assessment of any movement disorders • assessment of nutritional status, diet, and level of physical activity.	Not applicable during the period under review.
Before starting antipsychotic medication, offer the person with psychosis or schizophrenia an electrocardiogram (ECG) if: • specified in the summary of product characteristics (SPC) • a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure) • there is a personal history of cardiovascular disease or • the service user is being admitted as an inpatient.	ECGs arranged during treatment.
Treatment with antipsychotic medication should be considered an explicit individual therapeutic trial. Include the following: • Discuss and record the side effects that the person is most willing to tolerate. • Record the indications and expected benefits and risks of oral antipsychotic medication, and the expected time for a change in symptoms and appearance of side effects. • At the start of treatment give a dose at the lower end of the licensed range and slowly titrate upwards within the dose range given in the British national formulary (BNF) or SPC. • Justify and record reasons for dosages outside the range given in the BNF or SPC. • Record the rationale for continuing, changing, or stopping medication, and the effects of such changes. • Carry out a trial of the medication at optimum dosage for 4 to 6 weeks.	Not applicable during the period under review.
Monitor and record the following regularly and systematically throughout treatment, but especially during titration:	Evidence of some of this monitoring taking

Standards	Available to Mr J
• response to treatment, including changes in symptoms and behaviour • side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (for example, the overlap between akathisia and agitation or anxiety) and impact on functioning • the emergence of movement disorders • weight, weekly for the first 6 weeks, then at 12 weeks, at 1 year and then annually (plotted on a chart) • waist circumference annually (plotted on a chart) • pulse and blood pressure at 12 weeks, at 1 year and then annually • fasting blood glucose, HbA_{1c} and blood lipid levels at 12 weeks, at 1 year and then annually • adherence • overall physical health.	place during treatment.
The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.	Yes.
Discuss any non-prescribed therapies the service user wishes to use (including complementary therapies) with the service user, and carer if appropriate. Discuss the safety and efficacy of the therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.	Not applicable.
Discuss the use of alcohol, tobacco, prescription and non-prescription medication and illicit drugs with the service user, and carer if appropriate. Discuss their possible interference with the therapeutic effects of prescribed medication and psychological treatments.	Yes.
'As required' (p.r.n.) prescriptions of antipsychotic medication should be made as described in recommendation 1.3.6.3. Review clinical indications, frequency of administration, therapeutic benefits, and side effects each week or as appropriate. Check whether 'p.r.n.' prescriptions have led to a dosage above the maximum specified in the BNF or SPC.	Yes.
Do not use a loading dose of antipsychotic medication (often referred to as 'rapid neuroleptisation').	Yes.
Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).	Yes.
If prescribing chlorpromazine, warn of its potential to cause skin photosensitivity. Advise using sunscreen if necessary.	Not applicable.

Standards	Available to Mr J
How to deliver psychological interventions	**Not applicable.**
Monitoring and reviewing psychological interventions	**Not applicable.**
Competencies for delivering psychological interventions	**Not applicable.**
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	**Not applicable.**
Promoting recovery and possible future care **Pharmacological interventions**	
The choice of drug should be influenced by the same criteria recommended for starting treatment	Yes.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	No.
Consider offering depot /long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	Yes.
Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics) • take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.	Yes.
Employment, education, and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	Yes.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	Yes.

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