An independent review into the care and treatment of a mental health service user Mr D in the North East

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Our Report has been written in line with the terms of reference set out in the independent review into the care and treatment of Mr D. This is a limited scope review and has been written 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Events which may occur outside of the timescale of this review will render our report out-of-date.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. However where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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1 Executive summary

1.1 On 20 March 2019, Mr D told the police he had stabbed and killed his 55-year-old mother. Aged 34, he was at that time under the care of a local Psychosis Community Mental Health Team and had been since 2009. Mr D was subsequently transferred to hospital and was later found guilty of manslaughter by reason of diminished responsibility. He remains in hospital.

1.2 On 31 July 2019, a serious incident investigator completed a Serious Incident Review Report on behalf of Tees, Esk and Wear Valley NHS Foundation Trust [TEWV], into the care and treatment of a service user Mr D.

1.3 Subsequently, NHS England and NHS Improvement North East & Yorkshire (NHS England hereafter) commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake a desktop review of TEWV's internal investigation and to consider the care and treatment of Mr D, ensuring that the investigation's key lines of enquiry had been adequately considered and explored and highlighting any areas requiring further examination.

1.4 This review follows the NHS England Serious Incident Framework[1] (SIF) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] The terms of reference for this review are given in full at appendix A.

Independent review

1.5 This independent review was carried out by Dr John McKenna, retired NHS consultant forensic psychiatrist.

1.6 The report was peer reviewed by Dr Carol Rooney, Associate Director, and Mr Nick Moor, Partner, Niche. The review team will be referred to in the first-person plural throughout the report.

1.7 Undertaking the review involved compiling a comprehensive chronology of events by reviewing all available mental health records and GP records, conducting staff interviews, and reviewing a number of TEWV policies.

1.8 In this review, Mr D's background and history of contact with mental health services is summarised. A general overview of the TEWV report is then provided. We note some disparity between the report's terminology and that of the relevant Trust policy and NHS England Serious Incident Framework. It is not clear that two of the key areas to be addressed as set out in the Terms of Reference were addressed in the report's conclusions.

1.9 Mr D was first regarded as suffering from a psychotic disorder in custody in 2005, and after release was followed up by the local Early Intervention Team. There had by this point been detailed records made regarding his history and early presentation, and there was clear evidence of close co-working between prison, probation and forensic and 'general' mental health services. Care was

[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 incidentshttps://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents*

then reviewed, and care planning was documented, in line with the principles of the Care Programme Approach (CPA). Further information and detail was recorded during the 2006 - 09 admission, during which Mr D made further disclosures about past violent and aggressive behaviours and psychotic symptomatology at times became floridly evident. The risk-relevant aspects of these findings were regularly and clearly explored and set out in various multi-disciplinary meetings, CPA review meetings, multi-disciplinary reports (e.g., for Tribunal hearings) and risk management documents (e.g., HCR-20[3]). We note that the Trust report does not comment on certain changes or lack of clarity in Mr D's care arrangements.

1.10 We conclude that the absence in the records of any statement or review regarding the mother's potential vulnerability, and whether this did or could engage a consideration of safeguarding, is surprising when considered against the known facts in this case. Given the known background, we find it surprising that the Trust report concluded simply that there had been '*no recent safeguarding concerns'* without exploring any earlier concerns or considering how, or if, the care team(s) had taken known historical and risk assessment factors into account in considering the issue of safeguarding during more recent care.

1.11 NHS England contacted Mr D at the start of the investigation, explained the purpose of the investigation, and sought Caldicott Guardian approval for consent to access relevant records. We met with Mr D to discuss his perspectives on his care, and used clinical information from the Trust and GP records.

1.12 We were not able to speak to Mr D's next of kin as no records of their whereabouts was held by the Trust.

1.13 A full list of all documents we referenced is at appendix B.

Conclusions and findings

1.14 In our view, there are four issues relating to care arrangements and practice which were considered in the TEWV investigation, but which merited further challenge and exploration.

1.15 These relate to:

- care plan accuracy;
- assessed need for supervision;
- role of clozapine[4] clinics;
- and contact with Mr D's mother.

[3] *HCR-20 is a tool used to assess risk of violence. HCR-20: Assessing risk for violence (Version 2) 1997. Burnaby, British Columbia, Canada: Mental Health, CD Webster, KS Douglas, D Eaves, SD Hart; Law, and Policy Institute, Simon Fraser University.*

[4] *Clozapine is an antipsychotic medication used to treat schizophrenia in patients unresponsive to, or intolerant of, conventional antipsychotic drugs. https://bnf.nice.org.uk/drug/clozapine.html*

1.16 We conclude that the disparity between actually recorded and apparently intended care planning (including supervision arrangements) merited further exploration, and that the Trust report does not consider either how or why this error emerged and then persisted unnoticed. We do not think that the associated 'learning point' was sufficiently addressed in the Trust report. We also concluded that there is a potential contradiction in professional views about the role and operation of clozapine clinics, which should also have been considered in the Trust review.

1.17 Bearing in mind Mr D's history and known circumstances (and also what was known about his mother) in our view it is concerning that community staff did not at any point document a discussion with Mr D around the potential benefits of involving his mother in care arrangements. Further there is no record of staff ensuring that his mother would know how to contact services in the event of crisis - nor is there a record of any community team discussion about the relative demerits and merits of such an approach. We also conclude that the issue of potential risk to mother does not seem to have been formally revisited at any point after the hospital admission (when non-consensual disclosure to, or warning of, his mother had been actively considered). In fact, records suggest that from 2015 onwards potential risk to her was not regarded as an active issue, and she essentially failed to appear in his records (despite remaining an important person in his life).

1.18 We conclude that the most important area of learning identified relates to care planning. However, we think the report's scope around this is too narrow, particularly in missing potential opportunities for considering the wider or systemic processes involved in care planning and risk management in practice.

Recommendations

1.19 This independent review has made six recommendations for the Trust, five of which (Recommendations 1, 2, 3, 5 and 6) relate to the processes around reviewing and reporting upon serious incidents within TEWV (as set out in the Trust's Incident Reporting and Serious Incident Review Policy.[5]

Recommendation 1
The definitions of level of investigation used in the Incident Reporting and Serious Incident Review Policy should be changed to the definitions used in the NHS England SIF.

Recommendation 2
The Trust should ensure that contact with family of victims and perpetrators is included as a 'standing' or 'default' terms of reference for future serious incident reviews of this type.

[5] *Incident reporting and serious incident review policy CORP-0043-v8.2*

Recommendation 3
The Trust should provide assurance of the quality of serious incident reports of this nature. This could include consideration of whether the internal review process for submitted reports should include use of specific standards agreed in advance (such as those used in Appendix C of this report).

Recommendation 4
The Trust must revise internal policies and procedures relating to the functioning of 'clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.

Recommendation 5
The Trust should review the operation of 'RCA meetings' as set out in the relevant policy, with a view to making the process more robust in these types of cases. For example, it would be helpful for a senior clinician not directly linked to the treating team to be consulted by the reviewer(s) during the information gathering and report writing stages.

Recommendation 6

The Trust's Director Panel, as part of its role of responsibility for the final review of reports submitted by the Patient Safety Team, should consider whether the proposed actions against the report's second learning point reflects an adequate analysis of the findings and, therefore, would properly explore the issues involved.

It should formally set out the reasoning behind its conclusions and its proposed amendments, if any.

Good practice

1.20 Internal working between Trust teams and services was at least of good quality. While an in-patient, Mr D was on several occasions referred to different teams (psychiatric intensive care unit, general adult, low secure, medium secure, forensic rehabilitation), and the resulting assessments were timely and comprehensive, and followed by ward transfers where appropriate.

1.21 Similarly, in the community, there was sharing of information and of clinical responsibility between forensic and community teams after discharge, and then appropriate transfer across teams while in the community.

1.22 There is evidence of excellent inter-agency working during the period Mr D was in custody in 2004 - 05, at the points of initial assessment and subsequent assessment of whether hospital transfer was required, and at the point he was released from custody and subject to probation service supervision. Before this, there had been a good service response to requests

for assessment initiated by the probation service and police (in 2003 - 04). Subsequently, the Trust engaged in the Multi Agency Public Protection Arrangements (MAPPA)[6] framework during the period 2005 - 06 and in 2009.

1.23 Recognising that five of the recommendations are related specifically to the serious incident process, and one to clinical care, we have amalgamated these to assist the Trust with action planning, as shown below:

Action 1

The Trust should include these quality issues in the revision of policy and practice with reference to the Serious Incident investigation and review process:

- Definitions of levels of investigation used in the Incident Reporting and Serious Incident Review Policy should be changed to the definitions used in national guidance.
- Terms of reference should include family involvement as standard.
- Reports should be assessed against internal quality standards, including whether actions identified reflect an adequate analysis of the findings and are sufficient to address learning.
- Review the operation of 'RCA meetings' as set out in the relevant policy, with a view to making the process more robust, including external clinical input.

Action 2

The Trust must revise internal policies and procedures relating to the functioning of 'clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.

[6] *Multi-agency public protection arrangements (MAPPA) are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.*
https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa-guidance

2 Independent review

Approach to the review

2.1 At the time of the homicide Mr D was a 34-year-old, single, long-term unemployed man who lived alone in a rented flat locally. He had been under the care of a TEWV Psychosis Community Mental Health Team since being discharged from hospital in late 2009.

2.2 On the morning of 20 March 2019, Mr D presented himself at a police station and stated that he had stabbed his mother (aged 55) and killed her. Mr D was transferred from custody to hospital on 4 April 2019. On 12 July 2019, having pleaded guilty to manslaughter on the grounds of diminished responsibility, at Teesside Crown Court, Mr D was made subject to a hospital order with a restriction order, under the provisions of Sections 37 and 41, Mental Health Act 1983.

2.3 On 31 July 2019, a Serious Incident Investigator completed a Serious Incident Review Report on behalf of TEWV. Subsequently, NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to undertake a desktop review of TEWV's internal investigation. Niche is a consultancy company specialising in patient safety investigations and reviews.

2.4 This independent review was carried out by Dr John McKenna, retired NHS consultant forensic psychiatrist.

2.5 The report was peer reviewed by Dr Carol Rooney, Associate Director and Nick Moor, Partner, Niche. The review team will be referred to in the first-person plural throughout the report.

2.6 NHS England contacted Mr D at the start of the investigation, explained the purpose of the investigation, and sought Caldicott Guardian approval for consent to access relevant records. We used clinical information from the Trust and GP records.

2.7 Undertaking the review has involved compiling a comprehensive chronology of events by reviewing all available mental health records and GP records (a highly abridged summary is provided below).

2.8 We interviewed the TEWV reviewer (on 25 August 2020) and previous Psychosis team Manager (on 21 August 2020). We also reviewed a number of Trust policies, relating particularly to CPA and risk management - these are cited in the report.

2.9 A full list of all documents we referenced is at appendix B.

2.10 The draft report was shared with the TEWV, NHS Tees Valley Clinical Commissioning Group (CCG) and NHS England. This provided an 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 the victim's family

2.11 Contact with the victim's family has not been possible, as the Trust has no record of any contact details for her family members.

Contact with the perpetrator

2.12 NHS England wrote to Mr D at the start of the investigation, explained the purpose of the investigation, and asked to meet him.

2.13 We were initially advised that Mr D's clinical status meant that meeting him was not appropriate, we were however able to have a video call with him in late 2020 to discuss his perspective.

2.14 We offered Mr D the opportunity to meet with us prior to publication of the report. No response was received, but the report will be shared with the clinical team.

Terms of reference

2.15 The terms of reference (ToR) for the review are derived from the relevant section of the NHS England 'independent terms of engagement and reference'. These terms of reference have been used to structure our analysis:

- ToR1: Compliance with local policies, national guidance and statutory duties, including Duty of Candour and safeguarding.
- ToR 2: Assessment of care and treatment provided, including a review of the adequacy of risk assessments, risk management (specifically risks to others), and care planning (including carers assessment).
- ToR 3: Identification of any gaps or omissions in care not adequately addressed within the TEWV investigation.
- ToR 4: Identification of any areas that require additional investigation.
- ToR 5: Review of internal and inter-agency working.
- ToR 6: Assessment of progress made against implementation and effectiveness of recommendations.
- ToR 7: Identification of any notable areas of good practice in services as a result of recommendations.

Structure of the report

2.16 Section 3 provides some background about Mr D, followed by a summary of his contact with mental health services up to the point of the homicide.

2.17 Section 4 provides a review of the Trust's internal investigation, focusing on process, content and level of analysis.

2.18 Section 5 includes commentary on the internal investigation, against our terms of reference. We provide a commentary and analysis of the internal investigation, against each of our terms of reference. This includes an exploration of four areas of practice where we feel further exploration and / or challenge was merited.

3 Background

Personal history

3.1 Mr D had no contact with his father after his parents separated during early childhood. His childhood then involved residential instability, material deprivation and witnessing domestic physical abuse of his mother by men. He reported that his mother was a long-term drug user.

3.2 In early adolescence, Mr D came to the attention of social services because of disruptive behaviour and petty crime, and in 1999 he moved with his mother to a nearby small town. He did not attend school from this point, attained no qualifications, and remained long-term unemployed. Mr D began using alcohol and multiple illicit drugs from early adolescence, and by the age of 17 was using heroin and cocaine. By 2004 (aged 19), Mr D accrued a total of 12 offences, including two assaults (by battery) and six offences of theft.

3.3 Mr D has reported first experiencing odd beliefs and ideas in around 2001 (aged 16), and that around this period he twice tried to kill himself. He also reported that in 2002 he hit his apparently intoxicated mother and stabbed her in the neck, and that not long afterwards he hit her partner on the head with a hammer.

Contact with mental health services

3.4 Mr D's period of continuous contact with mental health services began while he was in custody in 2004, then aged 19. He was regarded as clearly psychotic, and a diagnosis of schizophrenia was then ascribed. This diagnosis was to be consistently, and exclusively, made throughout his contact with services, and this is completely in line with the clinical records reviewed.

3.5 Mr D was first assessed by an adolescent forensic psychiatrist, and then on several occasions by (adult) forensic services, before ultimately being released from custody in 2005 with follow-up by the Early Intervention Team (EIT), with a 'supplementary role' for the Forensic Community mental health team (CMHT). These assessments were thorough and detailed.

3.6 Mr D initially lived at a local bail hostel, was regularly reviewed by an EIT care co-ordinator, and continued to be prescribed oral antipsychotic medication (olanzapine).[7] From early 2006, his engagement with services faltered and, for want of a viable alternative, he moved in with his mother and her partner, both of whom were known to be prescribed methadone. From this point, medication compliance ended, and he restarted illicit drug use.

3.7 When admitted to a Trust mental health hospital in June 2006, Mr D appeared to be actively psychotic. He was again prescribed olanzapine, and his care was transferred back to the EIT after a three week admission. Mr D returned to his mother's address, stopped taking olanzapine and used illicit drugs. His functioning and mental state overtly deteriorated, and he was referred by the police after being arrested after a complaint of threatening behaviour in a public place.

[7] *Olanzapine is an antipsychotic medication.* https://www.nhs.uk/conditions/psychosis/treatment/

3.8 This was followed by a second episode of hospital care, which lasted nearly three years (September 2006 - August 2009). Mr D was for the first time detained under the Mental Health Act 1983 (MHA), under the provisions of Section 3. He initially spent time on a psychiatric intensive care unit and an open general ward, where he was prescribed a different antipsychotic (risperidone). Following Mr D expressing bizarre and sometimes violent ideas, some of which directly related to his mother, he was again reviewed by forensic services in late 2006.

3.9 In early 2007, Mr D was again referred to forensic services, because of concerns about violence risk and non-compliance in particular. He was eventually transferred to a low secure ward in June 2007. In early 2008, Mr D repeated his earlier disclosures about having assaulted his mother and her partner, and also specified five previously unreported incidents of animal cruelty and arson from around the same time (i.e., when aged about 17). He was transferred to medium secure conditions in January 2008 where he was first prescribed the antipsychotic drug clozapine, and then in April to a forensic rehabilitation ward.

3.10 By early 2009, Mr D's team were exploring post-discharge accommodation options, and this became a more pressing issue when in June it was realised that his Section 3 had inadvertently been allowed to expire some nine months earlier (meaning that Mr D was an 'informal' patient, and therefore had been unlawfully detained for those nine months).

3.11 Mr D then began a period of community care that lasted over nine years, up to the homicide (August 2009 to March 2019). Initially, medical oversight and care co-ordination was provided by a local Assertive Outreach Team (AOT), with additional input provided by the forensic adult outreach service. Mr D lived at a 24-hour staffed centre until moving to a different 24-hour staffed service locally in February 2010. Accordingly, the local AOT became involved, with a new care co-ordinator.

3.12 In September 2010, Mr D was discharged from forensic services and managed solely by the local Psychosis CMHT. Regular visits from the care co-ordinator continued. In January 2012, Mr D moved to a supported living flat, and in July a new care co-ordinator was appointed. It was recorded that he was continuing to make progress in his recovery, including an absence of overt symptoms. In late 2014, Mr D disclosed that he had been giving significant amounts of money to his mother's partner over some time, and around this time his mother moved in order to live alone. In early 2015, he moved to an independent flat, not far from his mother's new address.

3.13 In July 2016, a new care co-ordinator was appointed. Continuing clinical recovery was noted during reviews, and in late 2016 his care was regraded from 'enhanced CPA' to 'standard care'. At the same time, and as described in the TEWV report, he was also referred to the team-led clinic. While some correspondence indicated that this would mean, or was expected to mean, that Mr D would be seen for review just once or twice a year, he was in fact reviewed six times during 2017. In September 2017, a further new care co-ordinator was allocated.

3.14 The TEWV report explores service contact with Mr D from January 2018 onwards. In August, a new care co-ordinator was allocated. She saw him on 26 September and 9 October and may have seen him on 11 January 2019. Mr D was then seen in the 'clozapine clinic' on 14 January, 11 February and 11 March.

3.15 On the morning of 20 March Mr D, accompanied by a male friend, presented himself at a police station and stated he had stabbed and killed his mother (aged 55). He subsequently spoke of having stopped his medication several days previously, and of having used cannabis and cocaine recently. On the following day, Mr D was described as 'grossly deluded'.

4 Review of TEWV Internal Serious Incident Report

4.1 This review begins with a general overview relating to the credibility and thoroughness of the Trust's internal report, followed by further opinion structured according to the Terms of Engagement (which are provided in full at appendix A). Our detailed analysis of the report is at appendix C.

Level of investigation and methodology

4.2 The report describes the 'investigation type' as 'Level 2 Comprehensive'. This presumably refers to NHS England's Serious Incident Framework (update published March 2015), in which the level 2 'comprehensive internal investigation' is to be applied to 'complex issues which should be managed by a multi-disciplinary team involving experts and / or specialist investigators where applicable'.

4.3 It may be noted that TEWV's Incident reporting and Serious Incident review policy (Corp-0043-v.8.2) does not define levels of investigation in this way: it does not use the SIF level 1/level 2 distinction, and hence does not use the term 'comprehensive'. The policy does distinguish between 'serious incidents' and other classes of incident (moderate, low or no harm, and near miss). The policy states that a serious incident will be followed by a Patient Safety team review 'using RCA and relevant tools / template'.

4.4 While the level of investigation is appropriate to the incident, it would appear that although the Trust report does use the SIF terminology around levels of investigation, the relevant Trust policy does not.

Recommendation 1

The definitions of level of investigation used in the Incident Reporting and Serious Incident Review Policy should be changed to the definitions used in the NHS England SIF.

4.5 The report describes the methods used as 'single incident', 'incident mapping' and 'chronological timeline', and details what documentation and records were reviewed, and who was interviewed. It is not clear, however, which tools were used to gather, organise and analyse information.

4.6 The report refers to a root cause analysis (RCA) 'meeting' having been undertaken (and this terminology is also used in the Trust policy), although as indicated above it is not clear how RCA methodology was used in reviewing the case and developing the conclusions.

Lead investigator, timeliness, and standard of writing

4.7 The investigation was undertaken by a Trust Serious Incident (SI) investigator, who has received training in RCA methodology, and the report is a clearly written account of the investigation, using plain English and without typographical errors.

4.8 The report was completed on 31 July 2019, 95 working days after the incident. It is not clear whether an extension to the expected 60 day deadline was agreed with the relevant CCG.

Staff support

4.9 Staff are reported to have been provided with information regarding staff support services provided by the Trust, as well as support via line management. The 'RCA meeting' (on 11 June 2019) conducted as part of the investigation process is described as having been well attended, as was the subsequent feedback meeting (2 July 2019).

Terms of reference

4.10 The terms of reference for the investigation are included, and these are comprehensive and clearly set out. They include four "*key areas to be addressed*":

- appropriateness of care and treatment and its conformity with relevant policy;
- appropriateness of review frequency in relation to need and presentation;
- evidence of historical risk factors being reflected in care planning and risk assessment, including known safeguarding issues; and,
- inter-service liaison following arrest.

4.11 In the 'conclusions' section of the report, these four issues are reiterated, and it is stated that '*the review team concluded that the care and treatment provided to the patient by the Trust was appropriate'* and that '*there was evidence of good liaison between the Liaison and Diversion Team and the CMHT*'. Hence, the first and fourth of these issues is covered in the conclusions section of the TEWV report. We make a recommendation below (Recommendation 3) linked to this gap between the key areas of inquiry specified in advance and the analysis and conclusions set out in the final report.

Family and/or carer involvement and input

4.12 The terms of reference for the Trust report make no mention of family or carer involvement. The relevant policy does refer to the issue of contact with families of victims and perpetrators, however (CORP-0045-v8.2, para 4.5.3) and, separately, mentions '*the high level of importance of involving patients and carers'.*

4.13 Record review confirms that there was no known person in a caring role, and that this issue had been explored with Mr D as part of the care co-ordination role. Further, records also show that there was no known immediate or extended family member with whom the service user had had contact with for many years, bar the deceased. He had had no contact with his father, or with paternal half-siblings, since early childhood. The notes do refer to his mother

having moved to be near a relative in 1999, but there were no recorded contact details.

4.14 Accordingly, no family or carers were contacted, or identified, during the investigation.

Recommendation 2

The Trust should ensure that contact with family of victims and perpetrators is included as a 'standing' or 'default' terms of reference for future serious incident reviews of this type.

Inclusion of a summary of incident

4.15 There is a summary of the incident, and this details the outcome and the severity, as well as giving details about the immediate post-incident management of the service user.

4.16 The report sets out at some length the nature of negotiations between the Trust's Liaison and Diversion Team, adult mental health services, forensic services and the prison healthcare function, hence addressing the fourth of the specified key lines of inquiry (set out above under 'terms of reference').

Summary of service user's history and care

4.17 The report contains a summary of care from the service user's first contact with services in 2004 (under 'background'), and then a more detailed timeline ('chronology of events') from January 2018 onwards.

4.18 The background history is detailed and comprehensive. It states that Mr D's first contact with mental health services was in July 2004. In fact, the records show that he had previously been referred to local services on two occasions in October 2002 and in July 2003, by the police and probation service respectively. It was however in July 2004 that Mr D was first ascribed a diagnosis of paranoid schizophrenia. This diagnosis was consistently and exclusively made throughout the following period of nearly fifteen years, and the review found no evidence incompatible with this.

4.19 Particularly bearing in mind that the Trust investigation was triggered by the death of Mr D's mother (followed by his arrest on suspicion of murder), it is noteworthy that the background history does not set out in detail the ways in which the content of his morbid or delusional beliefs had directly and prominently related to his mother. Also, the Trust investigation does not mention at all the views taken by forensic service staff during his hospital admission (2006 - 09) regarding her vulnerability and his potential risk to her.

4.20 We also note that the third key line of enquiry (in the terms of reference, see above) referred to whether or not evidence of historical risk factors was reflected in care planning and risk assessment, including known safeguarding issues. This suggests that the issue of his mother's potential vulnerability might have merited more focused consideration in compiling the historical background. This issue is returned to in more detail below.

Care/service delivery, contributory factors/root causes

4.21 The TEWV incident report does not identify any care or service delivery problems, '*contributory findings'*, or any root cause(s).

4.22 It is assumed that the phrase 'contributory findings' - which is used at several points in the report - is equivalent to, or is intended to be equivalent to, 'contributory factors'. We would note that Section 5 ('Definitions') of the Trust's 'Incident reporting and serious incident review policy' refers to contributory factors, and not to contributory findings.

4.23 In this section, we have made a recommendation relating to the terms of reference set out in this report. We have also commented on an apparent gap between these terms of reference and the ensuing analysis and conclusions drawn, and on the use of the phrase 'contributory findings'. Elsewhere, we will note two instances where we felt that assurances provided to the reviewer while conducting the 'RCA meeting' should have led to further challenge or investigation.

Recommendation 3

The Trust should provide assurance of the quality of serious incident reports of this nature. This could include consideration of whether the internal review process for submitted reports should include use of specific standards agreed in advance (such as those used in Appendix C of this report).

Description of lessons learned

4.24 The report sets out four areas of learning. These relate to record keeping and are described in detail in the report's 'Findings' section. They are summarised as follows:

- Absence of clinical entry to indicate whether a planned patient contact took place.
- Reported failure of care plan to properly reflect intended frequency of patient reviews.
- 'Copy and pasting' of one record to another in clozapine clinic.
- Shredding of clozapine clinic cards post-incident.

4.25 The review is analysed against our terms of reference on the next section.

5 Analysis against the terms of reference

5.1 This section of the report provides an analysis of care and treatment and the internal review under the detailed headings of the terms of reference. The clinical policies and linked guidance reviewed during this review are listed at appendix B.

Compliance with policies and guidance (ToR1)

Duty of Candour

5.2 The legislative basis of the 'Duty of Candour' is set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and requires Trusts to act in an '*open and transparent way with relevant persons in relation to care and treatment provided to service users'.* A 'relevant person' is defined as '*the service user'* (or, sometimes, a person lawfully acting on their behalf), and a Trust is required to contact them after a *'notifiable safety incident'* has occurred - that is, '*any unintended or unexpected incident that occurred in respect of a service user …that … appears to have resulted in … the death of the service user … or severe harm, moderate harm or prolonged psychological harm to the service user'*.

5.3 In the case of Mr D, the incident at issue appears not to engage the Duty of Candour as the victim was not receiving services at the relevant time. Further, even if she had been, it is arguable that the strict relevance of the Duty of Candour could still be questioned, because the harm suffered was regarded as consequent to a criminal act (as opposed to having been an intrinsic element of 'care and treatment' provision or a regulated activity).

5.4 While these issues are debatable, the same Regulation does of course require Trusts to act '*in an open and transparent way'*, and this is expanded upon in detail by the Care Quality Commission (CQC) ('Regulation 20: Duty of candour', March 2015), which adopts the definitions of openness, transparency and candour used in the Francis Inquiry report. The CQC requires that Trusts must promote a culture that encourages candour, openness and honesty, and they should have policies and procedures in place to support this. The relevant TEWV policy (Duty of Candour Policy, ref: CORP-0064-v1.1) underlines these values. Openness suggests that information about a serious incident should be shared with families and carers, that concerns can be raised and that questions can be answered.

5.5 The NHS England Serious Incident Framework states that '*Patients and their families /carers and victims' families must be involved and supported throughout the investigation process'*, and that NHS England's approach to investigating homicides committed by those in receipt of mental health services is intended to *'ensure families (to include friends, next-of-kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations'*.

5.6 It is our opinion that while the Duty of Candour was not strictly engaged in this incident, the principles of good practice relating to being open, including the aims set out in Serous Incident Framework, mean that the Trust should have

attempted to contact family members as part of the internal investigation process (see also Recommendation 2 above).

Safeguarding

5.7 As mentioned above, a key line of enquiry set out in the Trust's own terms of reference was as follows: '*Was there evidence to suggest that historical factors were reflected within care planning and risk assessment including any known safeguarding issues in relation to the patient's vulnerability and risk to others?*' The report states - before the 'Background' section - that there were '*no recent safeguarding concerns identified up until the point of the incident*'. This statement is not revisited in the background, chronology or conclusions sections of the report.

5.8 Arguably, this statement fails to clearly address the question asked in the terms of reference. The records review undertaken for this report, however, suggests that there were known, and clearly recognised, indicators of potential vulnerability on the part of Mr D's mother, the victim. We summarise these below.

5.9 Mr D stated that as a child he had witnessed his mother being assaulted by male partners. It was recorded (in 2006, 2008 and 2009) that she had previously facilitated his drug use (and used his prescribed medication). In 2015, she was reported to have separated from her '*physically and emotionally'* abusive partner. It was known that Mr D had stabbed his mother in the neck (and then sucked blood from the wound) in around 2002, and a 2008 nursing report recorded that he had disclosed *"several physical assaults*" on her.

5.10 During the period 2006 - 07, it was noted that his mother "*featured in many of [his] bizarre delusions"*, such as that killing her would be followed by her rebirth and him obtaining special powers, and also that he blamed her for his putatively asymmetrical ears (which in turn were, in his view, preventing him from achieving fame and success as a rapper).

5.11 Indeed, in early 2008 (and not long after it was recorded that she had said that she was frightened of her son), it was recorded that a doctor and social worker had made arrangements to visit Mr D's mother and that they would "*ask about violence and communicate to her that he poses or may pose a risk to her in the future when in the community … given the risk he poses, there is a view within the care team that such a disclosure is appropriate"*. The records do not appear to indicate, however, whether any such meeting actually took place, or any outcome, and this issue was not documented again.

5.12 Towards the end of his hospital stay, Mr D had increasing, and unproblematic and positive, contact with his mother. This continued to be the case in the community from 2009 onwards, and there was nothing to indicate any short- or medium-term risk of violence to her, at least for as long as his mental state remained stable. The Trust report confirms that it was clear that Mr D visited his mother regularly, up to daily, and, indeed, that he had located himself to within walking distance of where she lived. She was also known to regularly visit Mr D at his address.

5.13 The potential historical indicators of vulnerability on the victim's part can be described as falling into three broad groups:

- a history indicating *general* vulnerability (she was known to have a history of longstanding substance misuse difficulties and to have been reportedly subject to domestic abuse);

- a history of more *specific* vulnerability relating to the service user (Mr D had assaulted her previously on several occasions, once by stabbing her in the neck); and

- the clinical *correlates* of that potential vulnerability (he had had bizarre thoughts related to assaulting her, i.e., relating to delusional beliefs regarding reincarnation, attaining special powers through violence, and blaming her for his putative facial deformities).

5.14 In late 2010, a newly allocated care co-ordinator recorded that Mr D was willing to consider his mother being offered a carer's assessment, and the care co-ordinator recorded his *'intention'* to *'determine what actual relationship dynamics are present'*. There is no evidence that this was followed up, and, indeed, after 2011 any references at all to the mother became less frequent in the running / daily record. From 2012, she is not mentioned in care plans or CPA documentation, other than as 'nearest relative'.

5.15 In fact, there was no record of any contact between CMHT staff and the mother at any point between 2009 and 2019, and the records confirm that Mr D had declined to involve her in his care planning process. There is also no record of whether the issue of contact with his mother was further discussed with Mr D, and no record of any discussion within the team about the issue of his mother's potential vulnerability, specifically around any risk of violence at the hands of her son.

5.16 Mr D's mother was known to have suffered intimate partner violence and to be a long-term drug user. Mr D had a history of violence against his mother, and when unwell he had evinced bizarre delusional and violent ideas in which she was implicated, such that forensic staff had at one point decided upon disclosing risk-relevant information to her regardless of Mr D's agreement.

5.17 It is obviously the case that during the period of community supervision (2009 to 2019) there was no suggestion of any untoward behaviour by Mr D towards his mother, and no evidence of concerning beliefs. Nevertheless, given the known background, it is surprising that the Trust report concluded simply that there had been '*no recent safeguarding concerns'* without exploring any earlier concerns or considering how, or if, the care team(s) had taken known historical and risk assessment factors into account in considering the issue of safeguarding during more recent care processes. On the other hand, it is clear that clinical teams did specifically consider the mother's vulnerability under the related rubric of 'risk assessment and management', and we return to this issue below (see 'contact with mother').

5.18 In summary, when considered against the known facts in this case, we think there should have been a frequent recorded consideration or review regarding the mother's potential vulnerability, and whether this vulnerability needed to be escalated as a safeguarding concern.

5.19 We also believe that the Trust report should have flagged up and explored this further.

Care, treatment and risk assessments (ToR2)

5.20 As indicated above, Mr D was first regarded as suffering from a psychotic disorder in custody in 2005, and after release in 2005 was followed up by the local EIT. There had by this point been detailed records made regarding his history and early presentation. There was also clear evidence of close co-working between prison, probation and forensic and 'general' mental health services. Care was then reviewed, and care planning was documented, in line with the principles of CPA.

5.21 Additional information and detail was recorded during the 2006 to 2009 admission, during which Mr D made further disclosures about past violent and aggressive behaviours and his psychotic symptomatology at times became floridly evident.

5.22 The risk-relevant aspects of these findings were regularly and clearly explored and set out in various multi-disciplinary meetings, CPA review meetings, multi-disciplinary reports (e.g., for Tribunal hearings) and risk management documents (e.g., HCR-20). As the Trust report confirms, during subsequent community reviews, it was consistently recorded that there was an extensive 'risk history', and this was highlighted as an 'alert' in the care record. Of course, and as will be explored below, the existence of extensive documentation is not equivalent to it being used effectively in practice.

5.23 At the point of hospital discharge (to a nearby town) in 2009, the initial shared care plan involved both forensic adult outreach service and AOT involvement, with the AOT providing medical input and care co-ordination (the care co-ordinator [CCo] being an AOT Community Psychiatric Nurse). Mr D continued to be prescribed the oral antipsychotic clozapine throughout his nine and a half years in the community, and accordingly he was seen every month at the 'clozapine clinic' in addition to the care arrangements described here. We comment further on the role and function of this clinic below.

5.24 Joint oversight continued within the CPA framework, and a different AOT and CCo took over when Mr D moved from one town to another in 2010. Later that year, Mr D was discharged from forensic services and his care was thereafter managed by the local Psychosis Team. At this point, Mr D was allocated to Cluster 17 ('psychosis and affective disorder; difficult to engage') of the Mental Health Clustering Tool (MHCT).[8] The reviewed care plan included the phrase: "*vigilantly monitor his mental health for relapse signatures of irritability, violence, thought disorder (thoughts of special powers, drinking blood and paranoia), hallucinations, sexual disinhibition*". This reflects in summary form the known concerns about risk in the event of relapse and was to be repeated in several subsequent care plans over the years. For example, in 2011 the care record stated that he was "*at high risk of relapse associated violence to others".*

[8] *The clusters describe groups of service users with similar types of characteristics. Mental Health Clustering Booklet, Dept of Health.*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216217/dh_132656.pdf

5.25 CCo responsibility was again transferred in mid-2012, and from 2013 onwards it was felt that Mr D's mental health, and general and social functioning, had improved '*greatly'* or *'dramatically'*. In early 2014, his CCo accordingly 're-allocated' him to MHCT Cluster 12 ('ongoing recurrent psychosis, high disability'). At the same time, while the care plan specified that *"ongoing monitoring and treatment is required to ensure his sustained recovery, minimise his risk profile*", the frequency of face-to-face review was reduced to three weekly. The running clinical record and linked CPA documentation continued to be regularly updated and comprehensive.

5.26 It was documented by the CCo that Mr D appeared to have a close and positive relationship with his mother. By no later than early 2015, Mr D reported, his mother had split up with her partner. It seems that from this point, following a brief stay in temporary accommodation, she lived alone. We would also note that there were four occasions when she was found by staff, incidentally, to be at Mr D's flat (sometimes while he was out) between late 2014 and late 2015. Also, up to early 2015, Mr D had been living in various versions of supported (i.e., 'staffed') accommodation, whereas from then on, he was living in an independent flat, which was within walking distance of his mother's new address. Further, from mid-2015 onwards, face-to-face reviews increasingly often (and later, almost exclusively) took place at locations away from his accommodation (e.g., in cafes).

5.27 It is possible, in retrospect, to speculate that the nature of Mr D's contacts and relationship with his mother may have changed in quality and / or frequency because of these multiple and approximately simultaneous, albeit individually relatively minor, developments. At the same time, the opportunities to incidentally be alerted to any altered dynamics (e.g., via residential staff reports of his or her movements or seeing her at his flat) would have decreased substantially.

5.28 The records do not indicate that this issue was discussed with Mr D, or discussed by the CCo within the team and as mentioned above, there was no documented contact between any staff and the mother. Indeed, as far as can be seen from the records, from around early 2016 onwards, Mr D's mother is no longer mentioned in clinical records or in care plans (except to be named as 'nearest relative').

5.29 In July 2015, a new CCo was allocated, and three weekly contact was maintained. In December 2015, Mr D was 're-allocated' to MHCT Cluster 11 ('ongoing recurrent psychosis, low symptoms'). In the Trust report, this re-allocation is reported to have occurred in December 2016, but this does not match our notes review.

5.30 During 2016, Mr D was given a maximum rating on all domains of the 'Recovery Star'[9], reflecting his consolidated clinical progress up to that point.

5.31 On 8 July 2016, the CCo wrote to Mr D's GP to state that because of his long-term stability he "*is to be regraded to standard care*[10] and Cluster 11", and

[9] *The Recovery Star is a tool used in one-to-one keywork or services which support individuals with a wide range of short and long term mental health difficulties. https://www.outcomesstar.org.uk/*

[10] *The reference to 'standard care' relates to TEWV's CPA policy ('The Care Programme Approach and Standard Care: Ref IA-0002-v6.1', approved January 2016), in which standard care is the alternative to CPA in people with, for example, more*

also mentioning that 'lead professional' visits would continue. It is unclear why the latter point was made because records clearly indicate that the re-allocation to Cluster 11 had taken place a year earlier. The reference to standard care is also confusing, because the Trust SI report states: "*The patient remained on 'enhanced' CPA until December 2016 (CPA review) … [he] was regraded to 'standard care' and cluster 11*."

5.32 It would appear that the CCo's letter of 8 July 2016 was wrong on two counts: the date of re-clustering (which had already taken place, six months previously), and the date of re-grading to standard care (which did not take place for another five months). This letter / issue is not mentioned in the Trust report, but it is mentioned here as it may be regarded as a further example of the confusion, or inconsistent messages, that the Trust report did find regarding how care planning arrangements were documented (which is considered further below).

5.33 In December 2016, a senior practitioner with the Psychosis Team wrote to Mr D to state that as a result of him making a good recovery and needing support less regularly, he was to be transferred to a "*team-led clinic*", that he would in future be reviewed every 6 - 12 months, and that the review would be undertaken by the writer or the team manager (i.e., not by a CCo or Lead Professional: [LP]). Later that month, the CCo wrote to the GP to state that Mr D was to be regraded to standard care, and that he was to have '2 - 4 weekly contact' with his LP (although the letter also refers to the CCo role).

5.34 The records do not state what the 'team led clinic' reconfiguration involved, or how and by what criteria service users were selected for allocation. The Trust report does not mention the reference to a team-led clinic in December 2016, or that Mr D was transferred to this. We were told that the team-led clinic was introduced to reflect the reduced needs for routine supervision, especially for people whose needs had remained stable for a long time (such as Mr D). In addition, since some reviews could be undertaken by a senior practitioner rather than the care co-ordinator, this was intended to be a useful response to the increasingly high caseloads of care co-ordinators.

5.35 The Trust report also does not comment on the fact that within a one week period, one letter was sent out saying that Mr D would be seen by two senior team members once or twice annually, and another saying that he would be seen by his LP once or twice monthly. In fact, the Trust report states that the plan was for "*annual care plan and wellbeing reviews",* which does not seem to be entirely compatible with what the contemporaneous records recorded.

5.36 In any event, face-to-face contact tailed off substantially from 2017 onwards, with six such contacts during the year (there were three contacts during 2018, and perhaps one in 2019 up to March, see below). The CPA review in July 2017 was attended by Mr D and the senior practitioner, who wrote that he would see Mr D again in two months. The updated care plan referred to the practitioner as CCo, while also stating that Mr D was to have eight weekly contact with his LP. In September 2017, the senior practitioner introduced Mr

straightforward care needs rather than a picture of clinical complexity. Rather than a CCo, a Lead Professional (LP) leads on care and interventions for people supported on standard care.

D to his new CCo. She saw him on three occasions in all, the last being in December 2017.

5.37 It is unclear why at the July 2017 CPA review the senior practitioner agreed to review Mr D in two months, as this same practitioner had in December 2016 told Mr D that annual or bi-annual contact was appropriate. Also, the accompanying care plan refers to both CCo and LP roles (instead of only the latter). Furthermore, despite Mr D being subject to standard care rather than to CPA, a new CCo was introduced in September, whereas the policy suggests that an LP leads on care planning and interventions for people on standard care. The Trust report does not mention either this CPA meeting or the new CCo allocation.

5.38 The Trust report considers service user contact in more detail from 15 January 2018 onwards. On that date, the senior practitioner again held a CPA review with Mr D. He then updated the care plan, which stated that there would be "*arranged appointments*" with the LP (who is named as the staff member who in late 2017 was described as 'CCo'). The same care plan also states that there was to be "*2 - 4 weekly appointments with CC*". Like the July 2017 version, this updated care plan refers to both LP and CCo roles, and to two different accounts of planned contact *('2 - 4 weekly intervals'* vs *'at negotiated intervals'*).

5.39 As in previous reviews, the risk assessment document ('Safety Summary') was updated. The 'triggers' identified were substance misuse, disengagement from services and medication non-compliance (entirely in keeping with the known history). Again, reference was made to the 'extensive risk history', and to the need to consider this in the case of 'relapse signs'. The summary also continued to provide an extensive narrative around past risk-relevant behaviours, and recent developments. As the Trust report confirmed, the content of this summary had remained unchanged for several years by this point, reflecting the absence of significant events during that period.

5.40 There was planned to be CCo contact with Mr D on 2 February 2018, but this did not take place, and no clinical entry was made to explain this. On 6 February, a Support, Time, and Recovery (STR) worker telephoned Mr D and arranged to meet him on 16 February. This seems to have happened because the CCo was on sick leave. When she saw him on 16 February, she made a further appointment for 6 weeks, but this did not take place, and no explanatory clinical entry was made. There was no further involvement of the STR worker, and the notes do not state the rationale for this.

5.41 After 16 February 2018, Mr D was not seen, except at the clozapine clinic, until 26 September 2018, notwithstanding what had been set out in the last two care plans.

5.42 On 28 August 2018, the senior practitioner, who is described in the Trust report as the LP, telephoned Mr D to advise him that he had been allocated a new CCo. Although the Trust report states that Mr D was given the name of his "new Lead Professional", the notes clearly refer to her as "care co-ordinator". This apparent disparity is not commented on in the Trust report.

5.43 We were told that the terms care co-ordinator' and 'lead professional' are often used interchangeably, that the use of 'lead professional' means that the

service user is to be seen just annually, and that many service users subject to standard care do have a care coordinator. While we do not criticise this, we do note that where there is confusion, or at least inconsistency, about care planning arrangements, the interchangeable use of two designations that are in Trust policy apparently clearly separated can have the effect of adding to the ambiguity.

5.44 After the new CCo / LP reviewed Mr D in September 2018, the first face-to-face contact for 31 weeks, she arranged to see him in eight weeks. In fact, she saw him again on 9 September (having arranged a psychiatric appointment as he had complained of excess salivation).

5.45 The Trust report states that Mr D attended his annual LP / CPA review on 11 January 2019. We have seen no record confirming that such a meeting took place (such as a clinical entry, or minutes), and it is not clear that the Trust reviewer did either, as their report quotes not from any records but from an account given during the investigation *("The [LP] advised the reviewer that the only new information that was identified during the review was regarding the patient's knee problems"*).

5.46 The records do confirm that a case note was started on this date, and created by the CCo / LP, but nothing was entered. On 29 January, she updated the care plan, which again specified that "*8 week appointments with CC*" were to continue and wrote to the GP stating that there would be "*8 weekly contact with Lead Professional*".

5.47 As the Trust report confirms, during the entire period of community supervision up until the homicide, there had been no evidence of instability in Mr D's mental state, including psychotic symptoms, or of any problems with medication concordance.

Gaps or omissions in care (ToR3)

5.48 In our view, there are four issues relating to care arrangements and practice which were considered in the TEWV investigation, but which merited further challenge and exploration.

5.49 These relate to:

- care plan accuracy;
- assessed need for supervision;
- role of clozapine clinics, and
- contact with Mr D's mother.

Care plan accuracy

5.50 It is clear from the Trust report, and confirmed by our records review, that there was confusion or at least ambiguity in the contemporary care documentation about how often Mr D needed to be and would be reviewed, the designation of the reviewer, and how often reviews were planned to take place. This is in addition to the curious confusion over when re-clustering took place, and when standard care was first confirmed (see above).

5.51 We list below the recorded planned contact frequencies stated in successive review minutes and associated care plans, during the period of 'standard care'.

Date	Type of contact	Frequency
December 2016	Team led clinic	2 - 4 weekly contact/ 6-12 months
July 2017	CPA review & care plan update	8 weekly contact
January 2018	Care plan update	2 - 4 weekly / as arranged
January 2019	Care plan update and GP letter	8 weekly contacts

5.52 The second learning point identified in the Trust report states that although the care plan stipulated 8 weekly reviews, "*this was not the case and not the intention*", and hence "*the patient's care plan did not accurately reflect how often he would be reviewed by the Lead Professional".* The actions specified are that care plans will be updated by the CCo / LP, and that there will be an audit to check that this is happening.

5.53 In our view, this stated disparity between actually recorded and apparently intended care planning merited further exploration (especially, perhaps, when the alternative is to rely on post-incident accounts). The Trust report does not consider either how or why this error either emerged in the first place, or explain how it could have persisted for a little over two years, or why none of the three different professionals who undertook the care plan updates noticed or corrected this. If in fact there were wider or systemic issues relating to how care plans are in practice updated, or how care co-ordinator work is supervised and signed off by senior team practitioners, then the proposed actions (essentially, a retrospective checking of current care plans) would almost by definition fail to detect or correct them. We cannot therefore conclude that this 'learning point' was sufficiently addressed in the Trust report.

Assessed need for supervision

5.54 In the section discussing the January 2018 CPA review, the TEWV report reviewer states that they had been advised (by the treating team) that Mr D:

"was 'non-problematic', was in recovery and had sustained this for a long time … The team advised that the patient was only open to the team due to Clozapine monitoring and prescribing and that if it hadn't been for the medication needs, due to how stable he had been over a long period of time, he would probably have been discharged".

5.55 This post-event assertion is not explored or challenged in the TEWV report, and in our view it is very difficult to conclude that the claim, that bar clozapine

monitoring discharge would probably have occurred, is compatible with what was actually recorded in Mr D's care planning documentation.

5.56 The final care plan update (January 2019, two months before the homicide) contains the following two phrases:

"*is making very good recovery requiring however ongoing monitoring and treatment is required to ensure his sustained recovery, minimise his risk profile".*

"*monitor his mental health for relapse signatures of irritability, violence, thought disorder (thoughts of special powers, drinking blood and paranoia), hallucinations, sexual disinhibition. Monitor for indications of resumption of illicit substances / discontinuation with treatment*".

5.57 These two phrases are also found in the care plan dated January 2018, and in fact in each of the previous care plans going back to 2013. In the January 2013 care plan, two closely similar phrases are present, although the monitoring deemed necessary was described as '*vigilant'* rather than *'ongoing'.* In all subsequent care plans, however, the above two phrases are repeated unchanged.

5.58 In addition, the final (and unchanged) Safety Summary document reviewed alongside the care plan update in January 2019 contains the following phrase (which is quoted in the Trust report):

"It is imperative to reduce future risk that the patient has a comprehensive care package and a team who are able to offer identified PSI (Psychosocial Intervention) support and frequently re-evaluate the risks".

5.59 On the face of it, therefore, the then current care planning and risk management documentation stated that Mr D required ongoing monitoring (of his mental health), involving skilled staff, and frequent re-evaluation of risk. This seems incompatible with the (post-event) assertion, quoted in the Trust report, that Mr D would probably have been discharged due to his clinical progress and stability, were it not for the fact that he was being prescribed clozapine. It is surprising that this apparent incongruity was not challenged or explored (at all) in the Trust report.

5.60 The only alternative interpretation would seem to be the possibility that these three statements did *not* reflect the clinical judgements of the treating team at the time. If that was the case, then it would beg the question of why and how this further disparity between record and opinion emerged and was not corrected, over a period of several years and across the involvement of several care co-ordinators / lead professionals.

Clozapine clinic

5.61 Mr D reliably attended monthly clozapine clinics, the last such instance being 11 March 2019 (nine days before the homicide). No untoward changes in his mental health were noted at any of these clinics.

5.62 We have not seen a policy or similar document specifically relating to the functioning of these clinics. However, one Trust document, '*Standard Process Description: Clozapine one stop clinic and supply of medication'*, includes the

phrase '*Assess service user mental state and presentation'.* This fits with what is recorded in the Trust report:

During the appointment the clinician will have a discussion with the patient about their mental state ...

They [team] advised [the reviewer] that the pt was being seen 4 weekly at the clozapine clinic and if there were any concerns raised during these appointments then the clinic staff would have alerted the [LP] who would have taken the necessary steps to review the patient...

He was being reviewed by the same clinicians during the clozapine clinics and if they had any concerns they would have alerted the [LP] immediately ..."

5.63 The report also quotes the findings from several clinic attendances what Mr D *"presented as euthymic in mood and manner"* and that *"there were no signs of relapse".*

5.64 The implication from the Trust report is that clinical assessment is undertaken at the clozapine clinic, and that this activity amounts to a clinically relevant safety net, e.g., for picking up signs of relapse.

5.65 However, during this review, we were told by a member of TEWV's Patient Safety Team that the Trust Pharmacy Department had told them:

" ... please note that the "clozapine clinics" are not the setting where the patient's mental state is assessed, that would be done in separate outpatient review appointments with the clinical team ...

The clinics are generally run by staff who aren't qualified to assess the patient's mental state. There is a basic assessment of physical health and side-effects, and a check of concordance with taking the clozapine ... but that's as far as it goes".

5.66 This would imply clinic staff are neither qualified nor meant to formally assess mental states, which would seem to run against the 'safety net' model assumed in the Trust report.

5.67 In our view, this potential contradiction in professional views about the role and operation of these clinics was not considered in the Trust review: the opinions of the team were accepted at face value. If there is any ambiguity about their functioning, it would presumably be important to review this and, where necessary, provide clarity for staff.

Recommendation 4

The Trust must revise internal policies and procedures relating to the functioning of 'clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.

Contact with mother

5.68 We have discussed above what was known by staff about Mr D's mother and his relationship with her (in relation to safeguarding). The care records indicate that there was no direct or indirect contact between care team

members and his mother at any point during the period of community care 2009 - 19. Before considering whether this should have been given greater consideration as part of the Trust review, we here summarise what was recorded about his mother and their relationship.

5.69 Very soon after Mr D's initial discharge from hospital, he was known to be visiting his mother frequently and for extended periods, and he maintained that he wished to move to be nearer to her. In fact, his regular contact with her was then consistently recorded throughout the period of community care. During 2010, because of concerns about him giving money to her and her partner, the issue of appointeeship was discussed with Mr D at least twice. Later that year, his CCo discussed with him the possibility of his mother being offered a carer's assessment, but this does not seem to have occurred - perhaps because he declined this offer (later, he clearly stated that he did not regard his mother as a carer).

5.70 In 2011 and 2012, it was recorded that Mr D "*declines to involve her in his care such as inviting to CPAs*". In early 2012, Mr D moved to an address that was "*only a short walk*" from where his mother lived, and he continued to see her *"on most days*". In 2014, she also moved, reportedly in order to be nearer still to her son. In late 2014, shortly after Mr D disclosed that he had for some three years been giving money to his mother's partner, his mother separated and thereafter lived alone. As previously mentioned, there were four subsequent occasions where his mother was incidentally discovered to be alone at his flat (compared to none previously), and in March 2015 it was recorded that she visited him *"a lot".* We were told at interview that Mr D's mother was often asked about during contacts with him.

5.71 A 'FACE'[11] Risk Assessment document was updated in January 2014, by the then CCo. This was a 'running update' of pre-existing and serially updated versions going back to late 2009. The 2014 update confirms that '*persons potentially at risk'* included staff, public and *'parent'*. The template question *'Are the person's carer(s)/family aware of possible risks?'* is answered 'yes' (with the annotation *'[Mr D]'s mother has herself been victim of [Mr D]'s violence when mentally unwell').* When the assessment was then updated by the same CCo in January 2015, the answer to the *'parent'* being at risk remained at *'yes* (while that for 'staff' and 'general public' was switched to *'no'*). When they again updated this in July 2015, the answer to the 'parent' being at risk was switched from *'yes'* to '*no'*. There is no text or annotation indicating the reasoning behind this change, i.e., to indicate the grounds for re-grading the mother to no longer being a person potentially at risk.

5.72 From 2016 onwards, Mr D's mother is barely mentioned in clinical records and or CPA documentation. She was several times mentioned as 'nearest relative' but does not feature in any care plans from July 2015 onwards. On the multiple occasions where Mr D was formally reviewed by community team members during this period, there is no positive evidence that they specifically explored or inquired about previously expressed unusual ideas about death /

[11] *Functional Analysis of Care Environments (FACE) is a risk assessment tool. About FACE: the applications of a structured approach to mental health information, R Elzinga, F Meredith - Australian Health Review, 2001 - CSIRO*

reincarnation, about possessing special powers, and / or about unusual ideas regarding his mother.

5.73 Although it is repeated that there was no evidence of psychotic symptoms, it is impossible from the record to determine whether during this period Mr D was ever asked specifically about past symptoms involving his mother and considered to be relevant to risk of violence to her. The final (and previous) safety summary / risk assessment does not mention Mr D's mother other than to say he had previously seriously assaulted her.

5.74 The Trust report states the following (the context indicates that the reviewer was told this by staff as part of their investigation):

"although [he] did have contact with his mother, she was not involved with his care, had not attended appointments and he did not want her involved. They had lived separately for a long time … the reviewer was advised that his mother did know the contact details for the team and that she would contact them if she had any concerns as she had done this previously".

5.75 To deal first with the last element of this section, we have found no record of Mr D's mother contacting the team at any point previously, whether to raise concerns or for any other reason. This assertion, therefore, could well be straightforwardly incorrect, and we would question why it was accepted without challenge or exploration by the reviewer. There is also nothing in the record to indicate that Mr D's mother had (or had ever been given) the contact details for the team or team members, and if this were the case then presumably, she would have struggled to raise any concerns if she had wanted to.

5.76 Hence, we note that it appears that the Trust report repeats two assertions about the mother which are not documented or supported in any way by the contemporaneous records. Below, we further note two different post-event statements that are accepted without challenge or exploration in the report – that Mr M's true supervision needs were different to those set out in the care plans, and that his need for secondary care at all was solely predicated on his being prescribed clozapine. There are obvious risks (of inadvertent bias or inaccuracy) attached to simply or solely relying on post-event statements provided by team members.

Recommendation 5

The Trust should review the operation of 'RCA meetings' as set out in the relevant policy, with a view to making the process more robust in these types of cases. For example, it would be helpful for a senior clinician not directly linked to the treating team to be consulted by the reviewer(s) during the information gathering and report writing stages.

5.77 We would also suggest that the statement about living *'separately for some time'* is potentially misleading. Mr D and his mother were known to live within walking distance of each other; both were known to have moved closer to each other; and, they were known to have had a close relationship and to see each other very regularly. While the fact of separate living could properly be

interpreted as indicating that Mr D lived independently, it would have been incorrect to further assume that it also meant they did not have a significant level of contact with each other. If anything, the level of contact may have been greater towards the end of the community supervision period than it had been at the beginning, as they lived closer to each other and she lived alone. Again, the level (and quality) of the contact does not seem to have been further explored during the Trust's investigation. Given the fact of the homicide we think that this was merited.

5.78 The above excerpt states that Mr D had not wanted his mother to be involved in his care, and this is borne out by clinical records. It is clearly documented that Mr D stated that he did not wish his mother to attend his CPA meetings, and that he did not regard his mother as having a carer role in his case. This is of course a sensitive and often difficult issue, and one which has attracted significant good practice guidance, e.g., from the Royal College of Psychiatrists and Rethink, as well as being considered in TEWV's CPA policy and risk management policy.

5.79 The Royal College of Psychiatrists notes (in Good Practice Guidance: Confidentiality and Information Sharing, College Report 209, 2017) that providing information to family members can be helpful for service users (including notifying the health care team), specifying that:

"You should discuss confidentiality and information sharing with the patient at an early stage. You should respect their wishes and clearly record them in the notes. You should ensure that the patient understands the benefits of sharing healthcare information with their family…"

5.80 Rethink (information leaflet, see appendix B) states that professionals should make sure that patients understand the benefits of information sharing, e.g., knowing the care plan and crisis plan, and knowing what treatment is being prescribed.

5.81 This may promote care, and support in a crisis: "*Professionals should regularly talk to your relative about sharing information with … relatives".*

5.82 The Trust's CPA policy states that:

"Carers / family will be involved wherever possible in assessment and care planning (with the person's agreement) as they are usually crucial in supporting wellbeing, safety and recovery …

There is evidence that outcomes are improved when [carers, families and other supporters] are appropriately informed, consulted and involved in decisions about the care and treatment of the person they support…

Every effort should be made to gain consent from the person by explaining the benefits of sharing information, whilst respecting the person's right to confidentiality…

If the person does not give their consent to share the care plan with their carers or family then general information in relation to support, safety and wellbeing should still be provided.

Carers / families and supporters should be advised of any risks to themselves … They should know who and where to contact if they have concerns about risks".

5.83 The Trust's risk management policy (Policy for harm minimisation: a recovery-orientated approach to clinical risk assessment and management Clin-0017-v7) also states:

"Discussions with SU should aid the decisions about sharing information with carers and help inform how the needs of both parties can best be met whilst respecting the SU's rights to confidentiality and the legal requirements to share".

5.84 Bearing good practice guidance and Trust policy statements in mind, and particularly in light of Mr D's history and known circumstances, we think it is concerning that community staff did not at any point document a discussion with Mr D around the potential benefits of involving his mother, and / or staff ensuring that his mother would know how to contact service in the event of crisis, nor is there a record of any community team discussion about the relative demerits and merits of such an approach.

5.85 We would further note that the issue of potential risk to mother does not seem to have been formally revisited at any point after the hospital admission (when non-consensual disclosure to, or warning of, his mother had been actively considered). In fact, records suggest that from 2015 onwards potential risk to her was not regarded as an active issue, and she essentially failed to appear in his records (despite remaining an important person in his life).

5.86 As we have previously noted, and in agreement with the Trust report, Mr D had remained clinically stable (in terms of symptomatology and improved social and personal functioning) for many years prior to the homicide, and we have no reason to doubt that the level of short- and medium-term risk would be assessed as low as a result. Indeed, the risk of relapse would also be regarded as low. Nevertheless, we think the Trust investigation could usefully have considered whether the team should have formally reviewed the issue of contact with mother as an option for risk management in this particular case and as a matter of good practice in general.

5.87 The present practice around investigations into the care of an individual appears to require Trust reviewers to rely on post-event discussions with staff who were directly involved in that care and / or who are team colleagues of those who were. It is possible that this might reduce options for further challenge or exploration of key emerging issues.

Additional investigation (ToR4)

5.88 We have not identified any areas that in our view require additional investigation. We have described above issues which were considered in the Trust report, but which in our opinion merited some further challenge as part of the investigation process.

5.89 The only additional comment we would make relates to GP contacts. The TEWV reviewer was advised by Mr D's GP surgery that there had been six consultations from January 2018 onwards, and "*none of them were related to*

his mental health". For the sake of completeness, we would note that there had been two consultations where Mr D requested correction of his ears. The GP did not raise any concerns about this. It is possible that if this had been reported, then Mr D might have been asked in more detail about this matter, given that in the past he had expressed unusual ideas about his ears and appearance when acutely unwell. The mental health team could not reasonably have been expected to have known about this, and a review of the notes shows that he did not repeat these concerns to mental health staff.

Internal and inter-agency working (ToR5)

5.90 In our view, internal working between Trust teams and services was of at least a good quality. While an in-patient, Mr D was on several occasions referred to different teams (PICU, general adult, low secure, medium secure, forensic rehabilitation), and the resulting assessments were timely and comprehensive and followed by ward transfers where appropriate. Similarly, in the community, there was sharing of information and of clinical responsibility between forensic and community teams after discharge, and then appropriate transfer across teams while in the community.

5.91 We do note however that we have not been able to review any formal description or policy document relating to 'team led clinics', and as already mentioned, any documented account of how, and for what reasons, Mr D was transferred to such a clinic in late 2016. The Trust report does not mention this.

5.92 There is evidence of excellent inter-agency working during the period Mr D was in custody in 2004 - 05, at the points of initial assessment, subsequent assessment of whether hospital transfer was required, and at the point he was released from custody and subject to probation service supervision. Before this, there had been a good service response to requests for assessment initiated by the probation service and police (in 2003 - 04). Subsequently, the Trust engaged in the MAPPA framework during the period 2005 - 06 and in July 2009 (prior to discharge from hospital, and when the MAPPA screening panel advised single agency management). Mr D's case was closed by MAPPA in late 2011.

5.93 Although not directly linked to understanding the incident, we have seen also clear evidence of good internal and inter-agency working in the hours and days after the incident, during which time Mr D was reviewed at a police station, in custody, in a custody health setting, and then transferred to hospital.

Progress made against recommendations (Tor 6 &7)

5.94 This includes implementation and effectiveness of recommendations, and identification of any notable areas of good practice in services as a result of recommendations.

5.95 The Trust report identified no care or service delivery problems, contributory findings or root cause. This is also our conclusion, but as indicated above we have concluded that there are areas which might have been usefully explored during the investigation, especially in discussions with team members and service managers. These relate to the updating and relevance of care planning and risk management documents, the role and function of clozapine

clinics, and the issue of contact with mother (and discussion of this with Mr D). The report has been shared with the relevant CCG and clinical teams.

5.96 We think that the key area of notable practice relates to consistent internal and external working between teams and agencies, at the point of Mr D's first referral to services, during his three year hospital admission, during his nine year community tenure, and in the period after the homicide.

5.97 Of the four areas of learning identified in the Trust report, which were described to us as incidental findings (rather than indicating contributory factors). We would agree with that viewpoint, but would single out one of them, the second, as being of more particular importance in detecting a potential area for systemic analysis and improvement in care delivery. The other three seem to be quite specific to a particular service context.

First area of learning

5.98 The first area of learning is that there was no evidence in the clinical record that a planned appointment (16 April 2018) took place "*or a rationale as to why it had not. In addition to this no further involvement from the STR worker was deemed to be necessary. However, the rationale for this decision was not reflected within the clinical records. Ensuring that any missed appointments or cancellations and rational [sic] for clinical decisions are recorded within the clinical record has been identified as an area of learning*".

5.99 There are then four actions:

- This will regularly be reviewed in staff supervision.
- Staff will record 'Did Not Attends' (DNAs) in clinical records.
- Clinical records will reflect clinical outcomes.
- Team Manager to raise this within the team governance meeting and in regular team nurses forums.

5.100 We were told at interview that the involvement of the STR worker had been triggered by the long-term unplanned absence from work of the CCo (and the records show that the same STR worker had also seen Mr D in the clozapine clinic). While we have not seen evidence of how these actions have been implemented, it appears to us unlikely that the record gap reflects a systemic problem with record-keeping, and hence that it requires actions beyond the normal operational practice within the team around maintaining a proper record.

Second area of learning

5.101 We think that the second is probably the most important, in terms of thinking about possible systemic areas for improvement in care and service delivery. This issue is mentioned in the second of the four areas of learning identified in the TEWV report:

"The patient's care plan did not accurately reflect how often he would be reviewed by the Lead Professional; the care plan stipulated that reviews would take place every 8 weeks however, [sic] this was not the case and was

not the intention. Ensuring that care plans accurately reflect the frequency of intended reviews has been identified as an area of learning for the team".

5.102 The stated 'actions' are as follows: *"All care plans to accurately reflect the frequency of reviews; this will be updated by the Care Coordinator / Lead professional" and "The team will undertake an audit to check this is happening with the team".*

5.103 We do not know directly whether these actions have been completed. However, and as indicated above, we believe that in any event these actions merely address the 'what' but not the 'how' of the problem identified. We also believe that the scope is too narrow because there is a linked finding (or assertion) that the patient would probably have been discharged from secondary care altogether were it not for him being prescribed clozapine (i.e., his other clinical needs probably did not merit or require ongoing follow-up). This position seems to us to be clearly incompatible with his assessed needs as stated in the care planning and risk management documentation (see above).

5.104 At interview, it was suggested to us that the care plan and risk assessment inaccuracies were not regarded as a systemic problem. However, we conclude that these findings lead to two questions which in our view are not sufficiently explored nor addressed by the proposed actions: how did this state of affairs come to be in the first place (and then to persist over time), and what then in practice was the role of the care planning documentation if it did not reflect the team's views of necessary and appropriate care?

5.105 This seems to touch directly on the wider process of reviewing and updating care plans, and on the professional use of care planning and risk management records in structuring and directing care at the point of direct contact (with service users and relevant others, such as family). To give one hypothetical example: if a newly allocated member of staff is not familiar with the content of such documents, then they may not take into account particular areas of risk when conducting clinical interviews.

Recommendation 6

The Trust's Director Panel, as part of its role of responsibility for the final review of reports submitted by the Patient Safety Team, should consider whether the proposed actions against the report's second learning point reflects an adequate analysis of the findings and, therefore, would properly explore the issues involved.

It should formally set out the reasoning behind its conclusions and its proposed amendments, if any.

Third area of learning

5.106 This relates to the finding that the clinical entries regarding Mr D's presentation recorded in the clozapine clinic bespoke template had been copied and pasted from one date to another. There are two actions:

Clozapine clinic staff will be made aware of the appropriate use of the template.

An audit will take place to ensure that there is no evidence of copy and paste within clinical records.

5.107 We have not seen evidence of how these actions have been implemented.

Fourth area of learning

5.108 In the clozapine clinic, staff complete paper monitoring cards, which are then transferred (uploaded) to the electronic record. These were "*mistaking [sic] shredded following the patient's remand to prison*". Action is essentially obviated by the fact that monitoring cards are not to be used at all in the future.

5.109 While the sequence of events leading to record destruction is not provided, it is surprising that a member of staff saw fit to destroy any records at all, without appropriate authorisation. In any event, however, the move away from paper records does provide a solution to this risk.

Summary

5.110 We have reviewed the Trust's report against the areas of learning identified in it and against our own terms of reference. We conclude that four practice-related areas considered in the report in fact merited further exploration and challenge as part of the internal review process. These are: contact with mother, clozapine clinics, care planning, and supervision needs.

5.111 Firstly, we conclude that the report could usefully have considered whether, as a matter of good practice more broadly as well as a specific action in this case, the issue of contact with Mr D's mother should have been formally reviewed (including discussion with Mr D). Second, we conclude that the Trust's policy and procedures relating to 'clozapine clinics' need to be revised in order to ensure that their function in relation to assessing mental health status is clearly described.

5.112 The third and fourth issues we have identified in part overlap. They concern the accuracy and consistency or coherence of the last few care plans for Mr D, and team opinions regarding the nature and frequency of monitoring and supervision that he was judged to have required. In particular, in both areas we concluded that the relevant risk assessment and care planning documents were inconsistent with the team's (post event) stated clinical judgements and intentions regarding Mr D's monitoring needs and current risks.

5.113 The recorded intended arrangements for the frequency with which Mr D would be monitored varied within and between care plans (and related correspondence), and in any event diverged from the team's stated view. Secondly, the assessment of risk and the actions recorded as appropriate to manage that risk (relating to the intensity and clinical quality of professional input) were in effect straightforwardly contradicted by what the clinical team told the reviewer as part of the Trust's investigation. In other words, the risk and care planning documentation set out as part of the CPA process for Mr D was both internally and externally inconsistent.

5.114 It is unclear how these discordances between care / risk documentation and the team's clinical judgement and behaviours arose and persisted, without detection by several staff. Further, these matters are not explored in the

Trust's report. The report's second learning point essentially proposes a cross-sectional audit of extant care plans.

5.115 We question whether this proposed action sufficiently addresses potential underlying or systemic issues, such as the process of care planning review, risk assessment review, and care co-ordinator supervision.

5.116 Recognising that five of the recommendations are related specifically to the serious incident process, and one to clinical care, we have amalgamated these to assist the Trust with action planning, as shown below:

Action 1

The Trust should include these quality issues in the revision of policy and practice with reference to the Serious Incident investigation and review process:

- Definitions of levels of investigation used in the Incident Reporting and Serious Incident Review Policy should be changed to the definitions used in national guidance.
- Terms of reference should include family involvement as standard.
- Reports should be assessed against internal quality standards, including whether actions identified reflect an adequate analysis of the findings and are sufficient to address learning.
- Review the operation of 'RCA meetings' as set out in the relevant policy, with a view to making the process more robust, including external clinical input.

Action 2

The Trust must revise internal policies and procedures relating to the functioning of 'clozapine clinics' in order to be satisfied that any function relating to formal assessment of attendees' mental health status is clearly described and supported.

Appendix A - Terms of engagement

Independent Terms of Engagement and Reference
Appendix 3 Serious Incident Framework 2015

These Terms of Engagement are for the provision of a mental health expert to support a Domestic Homicide Review (DHR) and have been set by NHS England and NHS Improvement Regional team with agreement of [local] Community Safety Partnership and the Independent DHR Chair

Terms of Reference for the activities of the Mental Health Expert will be developed further in collaboration with the investigative supplier, the Independent DHR Panel Chair and affected family members where appropriate. The following terms of reference will apply in the first instance;

Provide mental health and investigative expertise to assist the DHR Review Panel and the Independent DHR Chair and Independent Author

Provide constructive independent challenge to the detail of mental health information provided to the DHR

Assist the Independent Panel Chair to determine a health-related chronology

To contribute (if required) to the drafting of the mental health element of the DHR Report

Additionally, meet NHS England's requirements for a desk top review of the Trust's internal investigation with consideration and assurance of the implementation of the Trust's action plan

Purpose of the desk top review (NHS England and NHS Improvement)

To undertake a desktop review of the internal investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust to consider the care and treatment of Mr D, ensuring that the investigation's key lines of enquiry have been adequately considered and explored and highlighting any areas requiring further examination

As part of the desk top review consider assurances/evidence in response to the recommendations made within the Trust's internal investigation, outlining if there is sufficient evidence to demonstrate implementation and effectiveness.

Involvement of the affected family members and the perpetrator
Ensure that all affected family members are informed of the review, the review process and are offered the opportunity to contribute to the process including developing the terms of reference; agree how updates on progress will be communicated including timescales and format.

The Desktop Review will include:
The sourcing and review of relevant documents to develop a comprehensive chronology of events by which to review the investigations findings against.

Interviews with key personnel where necessary, to provide additional supporting information.

The review and assessment of compliance with local policies, national guidance including the application of the Duty of Candour and statutory obligations including safeguarding.

Assessment of the care and treatment received by Mr D including the review of the adequacy of risk assessments, risk management (including specifically the risk posed to others), care planning including carers assessment.

Identify any gaps or omissions in care not adequately addressed within the investigation undertaken by Tees Esk and Wear Valley NHS Foundation Trust.

The lead reviewer should highlight any areas that require additional investigation and raise these with the NHS England and NHS Improvement as the review progresses.

Constructively review internal and inter-agency working and communication and identify any gaps and potential opportunities for improvement and make appropriate recommendations. (may be included in DHR ToR).

Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.

Assess and report on the progress made against the implementation and effectiveness of the recommendations from the internal investigation.

Consider any partially implemented recommendations and identify possible organisational barriers to full implementation providing remedial recommendations as appropriate.

Identify any notable areas of good practice or any new developments in services as a result of the implementation of the recommendations.

Output

- Provide a written report to NHS England and NHS Improvement that includes findings and measurable and sustainable recommendations for further action where necessary. The report should follow both the NHS England style and accessible information standards guide.

- Provide a concise case summary to enable sharing of any wider learning.

- Provide NHS England with a monthly update, template to be provided by NHS England, detailing actions taken, actions planned, family contact and any barriers to progressing the review.

Support an action planning and/or learning event to promote learning opportunities for the provider.

Appendix B - Documents reviewed

TEWV documents:

- Policy for harm minimisation: a recovery-orientated approach to clinical risk assessment and management, Clin-0017-v7
- The Care Programme Approach and standard care Policy: Ref IA-0002-v6.1
- Incident Reporting and Serious Incident Review Policy, Ref CORP-0043-v8.2
- Standard Process Description: Clozapine one stop clinic and supply of medication

Other documents:

- Royal College of Psychiatrists College Report CR 2019 (third edition): Confidentiality and information sharing.
- Rethink: Can a professional share information with me about my relative? In: Factsheet 4, 'Confidentiality and information sharing', Rethink Mental Illness, 2014, updated February 2020.

Appendix C - Internal SI report quality assessment

The internal report has been assessed using our Niche internal 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, NHS England Serious Incident Framework (SIF) and the National Quality Board Guidance on Learning from Deaths. We also reviewed the Trust's policy for completing serious incident investigations, to understand the local guidance that investigators would refer to.

We evaluated the guidance available and constructed 25 standards for assessing the quality of serious incident reports based around the three key themes of credibility, thoroughness and whether the report was likely to lead to change in practice.

In the table below, we set out our review of whether the internal investigation met these standards, against our 'credibility, thoroughness and impact' framework.

Standard		Niche commentary
Theme 1: Credibility		
1.1	The level of investigation is appropriate to the incident.	The investigation is described as 'Level 2 comprehensive'. As defined by the SiF, comprehensive investigations are suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators. The TEWV Incident reporting and serious incident review policy Ref CORP-0043-v8.2 (January 2017) does not use the term 'comprehensive' and does not define levels of investigation.
		Standard met
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 do not include the scope and type of investigation.
		Standard not met
1.3	The person leading the investigation has skills and training in investigations	The lead was a Trust Serious Incident investigator – noted to have been trained in RCA Methodology.
		Standard met
1.4	Investigations are completed within 60 working days	The incident was on 20 March 2019, and the report was completed on 31 July 2019, 95 working days.
		Standard not met
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The investigation is written in clear English without typos, and the narrative is easy to understand.
		Standard met
1.6	Staff have been supported following the incident	There is a description of staff members having been provided with information regarding staff support services. The 'RCA meeting' was described as well-attended and staff were encouraged to reflect during the process.
		Standard met

Theme 2: Thoroughness		
2.1	A summary of the incident is included, that details the outcome and severity of the incident	There is a description of the account of the incident given by the patient after his arrest. The severity and outcome for his mother are described. Standard met
2.2	The terms of reference for the investigation should be included	The terms of reference for the investigation are included. Standard met
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 the methods used as Single incident. Incident Mapping Chronological timeline The report details what documentation as accessed, and who was interviewed. There is reference to a 'Root Cause Analysis (RCA) meeting' attended by staff involved, but it is not clear what tools were used to gather and analyse information. Standard met
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process	No family was contacted, the report notes that he was not in touch with extended family, following a review of the notes. However, there is no information about what possible extended family his mother may have been in touch with. There is mention of a friend who accompanied him to the police station, but the report does not give any indication whether it may have been appropriate to involve them in the investigation. Standard partially met
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care	No family was contacted. Standard not met
2.6	A summary of the patient's relevant history and the process of care should be included	There is a summary of his care from first contact in 2004, with a detailed chronology from January 2018 up to the incident in March 2019. Standard met
2.7	A chronology or tabular timeline of the event is included	A chronology is included within the report. Standard met
2.8	The report describes how RCA tools have been used to arrive at the findings	The report refers to a 'root cause analysis' meeting having been carried out, but it is not clear how the methods of root cause analysis have been used to arrive at the findings. Standard partially met

2.9	Care and Service Delivery problems are identified (including whether what were identified were actually CDPs or SDPs)	The report states that there were no care or service delivery problems identified during the course of the investigation. It is not clear how this conclusion was arrived at. Standard met
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors)	The report uses the phrase 'contributory findings' rather than factors. There were 'no contributory findings' identified during the course of the investigation. Standard not met
2.11	Root cause or root causes are described	The reviewer sates that they did not identify a root cause during the investigation. There was no explanation for this finding. Standard partially met
2.12	Lessons learned are described	There were four areas of learning identified during the course of the investigation, specifically in relation to record keeping, and these are described in some detail in the 'findings' section of the report. Standard met
2.13	There should be no obvious areas of incongruence	The ToR regarding safeguarding is not answered in any depth, and does not explore the particular term: *Was there evidence to suggest that historical risk factors were reflected within care planning and risk assessment including any known safeguarding issues in relation to the patient's vulnerability and risk to others?* The report states that there were no safeguarding concerns identified, which does not answer the question. Standard not met
2.14	The way the terms of reference have been met is described, including any areas that have not been explored	The conclusion section summarises how the terms of reference have been met. The description of family involvement does not explain why the Trust did not attempt to contact other relatives. Standard met
Theme 3: Lead to a change in practice – impact		
3.1	The terms of reference covered the right issues	The terms of reference did not include a reference to involving family or carers. Standard not met
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence	The report described what happened, with no structured analysis using recognised tools. There is no analysis of why it might have happened, and no discussion of contributory or human factors. Standard not met
3.3	Recommendations relate to the findings and that lead to a change in practice are set out	The report makes findings of 'areas of learning' rather than recommendations. Although these have actions suggested, they are not presented as recommendations with an action plan.

		The areas of learning appear to be incidental findings, and it is clearly stated that they are not regarded as contributory factors.
		Standard met
3.4	Recommendations are written in full, so they can be read alone	There were no recommendations made.
		Standard not met
3.5	Recommendations are measurable and outcome focussed	There were no recommendations made.
		Standard not met