Independent Review of the care and management of Mr F

NHS England reference: 2019-7600

Final report

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consequence uk

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Acknowledgements

This independent quality assurance review would not have been possible without the help of:

- The sister of Mr F who alerted the independent team to several factors that required consideration within the context of this review process
- Professor J Shaw, who worked with Trust staff to conduct the original internal review of Mr F's care and management
- The Associate Director of Nursing Quality and Professions at South West Yorkshire Partnership NHS Trust
- The independent clinicians who provided Consequence UK Ltd with an objective analysis of Mr F's care and management by the mental health Trust, and a perspective about the reasonableness of the findings of the Trust's own internal investigation.

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Executive summary

Purpose of the investigation

NHS England commissioned this learning and quality assurance review in line with the Serious Incident Framework for England 2015, which reflects the health circular guidance HSG 94/27 dated 10 May 1994, 'Guidance on the discharge of mentally disordered people and their continuing care in the community'. The pertinent paragraphs for this learning review are paragraphs 33 to 36, which focus on learning lessons for the future when "things go wrong". In this case, someone lost their life, and a patient of the NHS is charged with causing the victim's death[1].

The purpose of the independent process in this case was to determine the validity of the Trust's own investigation, which was led by a consultant in forensic psychiatry who did not and does not work for the Trust. Its other purposes were to:

- Determine if all the right lessons had been learnt
- To respond to any questions or queries raised by Mr F himself, or his family
- To respond to any questions raised by the victim's family

Terms of reference

The key terms of reference set down by NHS England and Improvement and agreed with Consequence UK Ltd were:

- Critical analysis of the internal investigation's key lines of enquiry and whether these were appropriate, considered and explored, and highlighting any areas requiring further investigation.

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

- Thorough review of the clinical records; assess the care and treatment received by Mr F including review of the adequacy of risk assessments, risk management, and care planning including carers' assessment.

- Explore whether Mr F's family had alerted professionals to any mental health concerns and, if so, how this was acted upon.

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

- Identify any gaps or omissions in care not addressed within the investigation commissioned by South West Yorkshire Partnership NHS Foundation Trust.

[1] Please note there have been several changes in national framework and significant change is about to happen again. chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

- Assessing the reasonableness of the original internal investigation in terms of method and methodology.

- Assessing and reporting on the progress made against the implementation and effectiveness of the recommendations from the internal investigation.

Main findings
Overall, the independent team concurred with the findings and recommendations of the Trust's own internal review, led by Professor Jenny Shaw.

These included:

- Fragmented information about Mr F that was not easy to access in a coherent manner. Moreover, the risk assessment format used was quite complex and the practice of cutting and pasting information between documents over several years resulted in inaccuracies and some confusion.
- Incomplete crisis and contingency planning. The plans lacked the expected level of detail and consisted only of contact numbers for within working hours and outside of working hours (this is available to all patients routinely). No early warning signs were documented, nor any specific agreed actions should the patient's mental health deteriorate.
- The lack of access to Mr F's home by the mental health team. Although this was outside the control of the professionals involved, it prevented professionals from having a more concerning perspective about Mr F. They had to rely on his personal accounts.
- The lack of engagement with Mr F's mother and sisters: They were not listened to as they could or should have been. Further, Mr F's mother was not offered an assessment of her needs which should have happened.

Conclusion
This is a tragic case that has had a lifelong impact on the lives of the victim's family, Mr F's family, and Mr F himself. There are no indications that the violent act that occurred was the direct result of Mr F's mental health disorder, nor by any act or omission by those responsible for the delivery of his mental health care.

It is possible that, had Mr F remained on a community treatment order and depot injection, a different outcome may have transpired. Such an analysis, however, is mere speculation. The decision to rescind Mr F's community treatment order was undertaken after a reasonable period of community treatment and a cautionary approach by the community mental health professionals involved. Its termination was only a matter of time. Retaining it indefinitely was not a viable option based on Mr F's stability within the community and his articulation nearer to the time of rescinding the community treatment order that he would comply with his treatment plan.

That he quickly wanted to move from depot to oral medication soon after was predictable.

The lack of robust contingency planning for when he disengaged with mental health services and/or his prescribed medication is the most significant criticism of his care.

It is made by both the Trust's own independent investigator and the independent CUK team commissioned by NHS England.

However, even if such a plan had been in place, there were no indications that he was relapsing in the weeks leading to the incident. The incident that occurred also had the hallmarks of premeditation, having followed a previous attack on the victim by the service user weeks prior to his death.

The second criticism was the lack of proactive engagement with Mr F's family. There were opportunities to achieve this without breaching any duty of confidentiality to Mr F. The delivery of a reasonable standard of family engagement would not have prevented the incident that occurred. However, it would have enabled the family to feel valued in their role as part of Mr F's support package.

The report author, the independent consultant psychiatrist, and the independent community matron extend their condolences to the victim's family.

Recommendations

The Trust can show that it has acted on all the action points set down in its action plan, constructed following its own internal investigation. The Trust's new approach to risk assessment, FIRM, is intended to address all the risk management practice and documentation concerns highlighted by its own investigation, this independent investigation, and via other investigations (internal and independent).
The recommendations below seek to address what CUK considers to be outstanding issues, and/or the need for auditable assurance that the actions already taken have delivered the improvements they were designed to achieve.

Recommendation 1:
What is required:

Where a service user is actively supported by a carer/family member or close friend, and those individuals are relied on by the service user for their wellbeing and stability, the care team must provide the opportunity for those individuals to share information with the care team on an 'as needed' basis. The service user must be aware of this facility and its necessity and be reassured that the care team will not divulge information they hold about the service user with friends/family without the express consent of the service user. Achieving this situation reliably requires service users, families, and frontline practitioners to engage and participate in the process design so that it works, and for the culture change necessary to ensure its success is brought about.

Recommendation 2:

What is required: The Trust is tasked with designing an audit approach that enables it to test the improvements it desired as a result of the safety improvements initiated prior to and after incident involving Mr F. The key areas that must be tested are the impact of FIRM, the new approach to risk assessment, risk management, and safety planning. Other significant areas include how all care teams communicate and engage with families and carers of service users. Such an audit must deliver a systems wide assessment and include the following types of activity:

- Focus groups of professionals, service users and families

- Peer review of record keeping, assessing content and quality of what is written

- Individual exploratory conversations (interviews) to investigate in-depth the experience of staff, patients, and families - particularly:

    - Design of risk reduction/safety plans and service user and family involvement
    - The confidence families have to contact a service user's care team
    - The ease with which the family/carers of a service user can contact the care team
    - The responsiveness of the care team as experienced by the family/carer

Recommendation 3
It is commendable that the Trust is developing the role of a family liaison officer to work with families and be a named point of contact through an incident investigation process. However, we recommend that the Trust ensures it embraces the principles of restorative practice after harm into the family liaison officer role, and seeks the advice and input of emerging thought leaders in these fields, including registered practitioners and facilitators in restorative practice, before finalising its approach.

1 Introduction

1.1 Why was an independent review commissioned?

On 26 March 2019, a service user of Southwest Yorkshire Partnership NHS Trust was arrested following the fatal stabbing of a member of the public. The service user was subsequently charged with murder.

In line with The Serious Incident Framework for England 2015, (appendix 1) [2] . The guidance says
"The regional investigations team should commission an independent investigation of mental health care related homicides when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past 6 months49 prior to the event."

The provider in this case, Southwest Yorkshire Partnership NHS Trust, took the initiative to instruct its own independent assessment of the service user's care and management in autumn 2019, six months after the incident occurred.

An additional independent review of the Trust's own investigation and assessment was subsequently commissioned by NHS England towards the end of 2021.

This CUK led independent review scrutinises the findings, conclusions, and recommendations emerging from the Trust's investigation. Consequence UK Ltd (CUK) is independent of the Trust and was appointed by NHS England.

1.2 The approach taken

Examining the Trust's initial investigation is an important aspect of providing assurance to the public that the right questions have been asked and answered, and that the right lessons are learnt to enable necessary improvements in clinical practice, systems, or processes. Ordinarily the independent review team would have access to all the information that informed the findings, conclusions and recommendations made by Professor Shaw. However, in this case all the material evidence had been destroyed following the Trust's acceptance of Professor Shaw's report. Therefore, CUK agreed with NHS England that in the first instance it would undertake a desktop review of Mr F's care and treatment using the available clinical records. The it would compare its considerations to the findings made by Professor Shaw. If the desktop review reflected the findings of Professor Shaw, then it was agreed with NHS England that re-interviewing frontline staff was not justifiable. However, the CUK interim findings report would be provided to the Trust and relevant staff to read and comment on. Staff were invited to contribute to the report in this way, as were the family of Mr F. The family of the victim did not respond to an invitation from NHS England to meet with CUK. The final report content was agreed between CUK, the Trust and Mr F's family, with CUK holding the final decision on amendments made.

1.3 An overview of what happened and relevant background information

[2] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

On 26 March 2019, Mr F stabbed a member of the public who was known to him. The knife pierced the victim's heart and he died of his injury. At trial, the judge accepted there had been no intention to kill but there had been an intention to cause serious harm. The trigger for the fatal assault appeared to be related to money reportedly owed to Mr F by the victim.
At the time of the fatal assault Mr F had 20 previous convictions. These included drug related offences and violent offences. He also had a documented history of gun related crime, weapons use, and a chaotic lifestyle history.

He was discharged from the low secure forensic service on 9 March 2015, via a CPA handover meeting. Mr F was introduced to his new care coordinator on 8 April 2015 by his previous forensic care coordinator. At this point it was clear that Mr F preferred face to face meetings at his mother's home and all correspondence to go via his mother's address. This arrangement had been established while he was under forensic services.

He remained stable in the community and requested the rescindment of his community treatment order in 2017. The request was granted following an assessment by a consultant psychiatrist. Soon after, Mr F requested a change in his medication from depot (by injection) to oral. Although depot was a more reliable form of medication for Mr F, his request was reasonable and there were no grounds for refusal. He was commenced on a medication called Aripiprazole, typically used for the maintenance of individuals with a diagnosis of schizophrenia. Mr F had such a diagnosis.

In the 12 months preceding the fatal stabbing of Mr F's acquaintance:

- Mr F was assessed twice in April 2018,
- Mr F's care coordinator spoke with him twice in May 2018
- Mr F did not attend a scheduled appointment on 24 May 2018
- On 18 June Mr F was assessed as euthymic, i.e., in a stable mood state. He was noted to be positive about his mental health but maintained minimal eye contact.
- On 1 July 2018 Mr F was noted to be compliant with his prescribed medication, not using alcohol and not using illegal drugs. One day later, at a psychiatric appointment, it was noted there were no mood problems. His sleep patterns were not concerning. He lived on his own with support from his mother. No concerning debts, alcohol intake, or illicit drug use was noted. The consultant psychiatrist noted the medication prescribed and that Mr F would be "stepped down to the community clinics in the near future".
- On 22 August 2018 Mr F was again reviewed. There were no signs of psychosis. He was maintaining regular contact with his mother. He was content with monthly reviews.
- Similar notes were recorded on 26 August 2018.
- On 24 October 2018, the clinical record reports that Mr F's stability continued. This situation prevailed from November 2018 to January 2019.
- On 21 February 2019 Mr F attended for his personal independence payment assessment. He was supported by his care coordinator. There were no signs of psychosis.

- On 6 March 2019 Mr F forgot a scheduled appointment at his mother's home. This was rescheduled for 3 April.

On 27 March the incident of violent and fatal assault occurred.

Although it was predictable that, without his medication or regular engagement with mental health services, Mr F may pose a risk of harm to others, there was no evidence of these factors, nor of instability in his mental health presentation, during the period preceding his fatal assault on the deceased. He presented as consistently stable. Furthermore, the circumstances of the assault are such that it is unlikely that the incident could have been prevented.

After the assault, a police investigation revealed the following in his home:

- Several knives
- Packets of illicit substances, including crack cocaine and heroin
- A baseball bat
- Nunchakus
- A long pole

Because Mr F always requested to meet the mental health professionals at his mother's home, no one was ever aware of these. Mental Health teams have no powers to enter the home of a patient and agreeing to Mr F's request to meet at his mother's was reasonable.

2 Terms of reference or key line of enquiry

The key elements of the initial terms of reference for the independent process were:

"The independent review will consider the internal investigation commissioned by South West Yorkshire Partnership NHS Foundation Trust.

The independent review will include:

- The sourcing and review of relevant documents to develop a comprehensive chronology of events, against which the internal investigation's findings will be considered.

- Interviews with appropriate personnel where necessary to provide additional supporting information.

- Critical analysis of the internal investigation's key lines of enquiry and whether these were appropriate, adequately considered and explored, and highlighting any areas requiring further investigation.

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

- Thorough review of the clinical records; assess the care and treatment received by Mr F including review of the adequacy of risk assessments, risk management, and care planning including carers' assessment.

- Explore whether Mr F's family had alerted professionals to any mental health concerns and, if so, how this was acted upon.

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

- Identify any gaps or omissions in care not adequately addressed within the investigation commissioned by South West Yorkshire Partnership NHS Foundation Trust.

- Constructively review information shared and communications between treatment teams, identify any gaps and potential opportunities for improvement, and make appropriate recommendations.

- To identify any areas of best practice, opportunities for learning, and areas where improvements to services are required with a focus on the period from 2013 to the date of the incident."

In addition, the independent team were tasked with:

- Assessing the reasonableness of the original internal investigation in terms of method and methodology.

- Assessing and reporting on the progress made against the implementation and effectiveness of the recommendations from the internal investigation.

- Identifying any notable areas of good practice or any new developments in services resulting from the implementation of the recommendations.

- Considering any partially implemented recommendations and identifying possible organisational barriers to full implementation, providing remedial recommendations as appropriate.

3 Communication with Mr F and his family

Initial contact was achieved between Mr F's family and CUK on 10 January 2022. This was followed by a face-to-face meeting via Microsoft Teams on 24 January. It was clear at that meeting that Mr F's family felt let down by South West Yorkshire Partnership NHS Trust. This sense of feeling let down was mostly because of a lack of proactive communication with Mr F's mother prior to the incident leading to this independent review and the absence of communication after the incident.

The lack of communication meant the Trust had no appreciation of:

- The personal cost to Mr F's mother because of the active support she provided to her son.

- The fact that neither Mr F's sister, nor his mother, had been given sight of the Trust's internal report prior to, nor after, its acceptance as a completed report.

- The concern held by Mr F's sister about her brother's contemporary wellbeing in prison, and her concerns about his mental health and whether he was receiving effective treatment by in-reach mental health services.

Mr F's sister told CUK that it was not until the conversation on 24 January 2022 that she felt informed in any way about what was happening. This meeting also acted as the lever to reconnect Mr F's sister with the senior management team in the Trust so that it could support her in finding out about what mental health in-reach was occurring for Mr F.

Between January 2022 and the completion of the interim report, CUK maintained contact with Mr F's sister by email, updating her regarding progress in the independent process and any delays in projected timescales.

4 Synopsis of the patient journey leading to the incident

4.1 Historical overview

Mr F is an individual with a diagnosis of schizophrenia. On 15 November 2012, he was admitted from HMP to the Bretton Centre under Section 35 of the Mental Health Act following significant deterioration in his mental state. He was floridly mentally ill, relaying bizarre, delusional beliefs that involved pseudo-scientific, pseudo-philosophical claims. He remained resident at this centre for several months.

In September 2013, a clinical psychologist who had assessed Mr F on 16 occasions compiled a report based on these assessments. Much of its content is not relevant to this independent process. However, the following excerpt is:
"Risk to others lies in his criminal activity and violence. Criminal activity more likely if he does not have a range of pro-social activities and contact with others, he gets bored and wants a buzz and gets involved in drug misuse. The risk of violence is increased if unwell and likely to make paranoid interpretations of other's behaviour. It noted that his limited reliance on others and sense of shame about illness will complicate attempts to prevent future relapse[3]."

When Mr F was discharged from the centre and returned to his own home, he was initially seen weekly and his medication was via depot injection. His outlook was positive. One month later, a family member raised concerns about possible illicit drug use but there were no discernible features of this in Mr F's mental health presentation.

Over the early period of his discharge from the Bretton Centre, Mr F engaged in regular illicit drug screening. These urine tests were negative for drugs.

At his outpatient appointments, Mr F was assessed as stable and confirmed his abstinence from illicit drugs.

At an outpatient review in March 2014, it was decided that Mr F's community treatment order would be renewed even though he was stable. A social circumstances report in April 2014 confirmed this decision was a prudent one. The same month (April 2014), his continuing stability, combined with the protective nature of the Community Treatment Order, led to the decision that Mr F should transfer to local services within the next six months. At this juncture, he was living full time at his mother's address, visiting his own address on a limited basis. Mr F had also applied for a council property near the centre of Huddersfield and was seeing his partner and son twice a week at his mother's home.

In June 2014, a reduction in Mr F's dosage of Paliperidone to 50 per month (via depot injection) was agreed to alleviate its sedating side effect. Mr F reported a beneficial impact a month later.

By September 2014 Mr F and his then consultant psychiatrist agreed to home visits at his mother's address every other week, and to attend as an outpatient three times

[3] Taken from page 23 of the internal investigation report compiled by Professor J Shaw.

per month. It was also acknowledged by Mr F that the community treatment order supported his compliance with his medication regime. It was further agreed that a programme of drug and alcohol screening would continue in order to support the clinical team should they have suspicions he was abusing these substances.

The concern regarding medication non-compliance was the primary reason for the consultant psychiatrist to recommend to hospital managers that Mr F remained on a community treatment order. He also recommended that Mr F should be managed by an assertive outreach team and not general adult community services. This was initially accomplished.

However, in December 2014, because Mr F was stable in his presentation and engaging well with the team, referral to a community mental health team was deemed appropriate as he no longer met the criteria for assertive outreach.

The community treatment order for Mr F was also renewed in December 2014.

4.2 Overview of the four years leading to the incident

A full handover of care occurred on 10 April 2015 that discussed both the necessity of the community treatment order and Mr F's risk profile. At this stage, Mr F had been in the community for 12 months with no substance misuse. His medication had been reduced and there were no signs of relapse. This was followed up with a care programme approach (CPA) review led by one of the consultant psychiatrists.

An excerpt of the risk history handed over states:
"They reviewed the risk at the CPA, it was noted he had 20 convictions for 38 offences from 1995, seven drug offences between 1995 and 2002 possession of cannabis, January 2002 possession of heroin and cocaine, May 2002 he received six-month prison sentence, two violent offences 1996 and ABH where he hit a guy who he believes was picking on his friends, he hit him with some wood and battery in November 2011. His partner came to pick up their child, [Mr F] made her drive a short distance, he [assaulted her], at the time he thought she was being unfaithful. There were 15 offences related to police court and prisons. It was noted that between 20 and 21 he took crack and IV heroin and intermittently drank alcohol."[4]

The plan at this stage was to hold visits with his care coordinator as well as outpatient visits with his new consultant psychiatrist on alternating weeks.

Within three months of transferring to a community mental health team, Mr F was complaining about his medication and attributing it to his low mood, occasional suicidal thoughts, variable sleep, and occasional paranoid ideation.
On 20 July 2015 he expressed concern that his "girlfriend was seeing other men" . According to the internal report written by Prof Jenny Shaw: "It was thought this was not delusional, [and it was noted that Mr F] discussed this insightfully about his diagnosis and treatment"[5].

[4] Taken from the internal investigation report written by Professor J Shaw – page 25
[5] From the internal report written by Prof Jenny Shaw page 26

Antidepressants were commenced on a trial basis. One day later, an individual connected to Mr F contacted the mental health services reporting concerns that he was becoming unwell and accusing his girlfriend of having an affair. His girlfriend had grown fearful of him.

In August 2015, his new consultant psychiatrist recommended the community treatment order be retained as Mr F had reported it was unlikely that, without it, he would continue to comply with his medication. The report compiled for hospital managers by this consultant also reported that Mr F was concerned about his jealousy towards his partner and questioned whether it might be delusional. The conditions for the removal of a community treatment order were clearly not in place.

During the subsequent month, Mr F reported that the introduction of an anti-depressant had helped his mood. He also reiterated his request that there was to be no contact with his mother. This same month, his community psychiatric nurse talked with Mr F about his non-engagement in the community and encouraged him to have face to face contact with the treatment/care team.

In early October, Mr F's sister raised a concern about possible illicit drug use, a deterioration in her brother's mental health, and possible paranoid behaviour. The next day, a mental health worker found Mr F was not at home when he visited. The health professional then went to Mr F's mother's home and found him there. He agreed to go with the health professional for his depot injection. Mr F was noted to be unkempt.

On 14 October, one week later, Mr F's community psychiatric nurse noted: "low in mood, deteriorate in self-care, uncooperative, defensive as to why he had not kept several appointments, agreed to home visits at mother's address, denied illicit drug use, urine sample taken, said he didn't agree with the CTO, did not want to appeal it, continued to withhold consent for mental health services to speak to mother, sister or ex-partner."[6]

One month later, Mr F reported he would not tell his care team if he were using illicit drugs and continued to withhold consent for the team to contact his family.

By December 2015, Mr F was feeling happier. He had started running. He reported a stable mood.

In February 2016, his regular community psychiatric nurse had an extended period of leave from work. At an appointment with is community consultant psychiatrist, Mr F also reported he was uncomfortable around people, that he found his depot helpful and would continue with it if not on a community treatment order. It was agreed that visits would take place once every three months.

Mr F remained stable, and a decision was made to reduce his depot injection (Paliperidone) prior to the review and renewal of his community treatment order. It was also decided that a recommendation would be made to continue with the community treatment order because of the reduction in depot medication. If Mr F

[6] Excerpt from internal investigation report written by Professor J Shaw

remained stable, then a consideration would be made at the next review on whether to remove the community treatment order at that stage.

Of specific note was an entry made in the psychiatrist's 2016 report:

- No psychotic symptoms since being referred to general adult services in March 2015
- Reliable at his attendance at outpatient appointments
- Reasonably reliable with his anti-depressant medication

On 24 October, Mr F was seen by his usual community psychiatric nurse at his mother's home. This professional detected no discernible change in Mr F's presentation now he had been on a reduced dose of Paliperidone (now administered five times weekly). Mr F reported being settled in his new flat but was not forthcoming about his daily activities.

Between October 2016 and May 2017 Mr F remained stable. He continued to report that his mood was low, but that he was better on anti-depressants than without them. He remained in contact with his son and was trying to do exercise. He continued in his refusal to engage in any activities linked to mental health services. He was available for most scheduled appointments with only a small number of 'did not attend' episodes.

In May 2017, his allocated community psychiatric nurse had a prolonged period off from work. Mr F was provided with contact details if he needed help/support. Community care contacts were less frequent after this. However, in August 2017 a health professional attended at his mother's home after finding Mr F not at his own flat the previous day. On this day (18 September), it was noted that Mr F requested changing from depot to oral medication along with seeking an appointment with his psychiatrist. The appointment occurred one week later.

Notably this was the first appointment with a new psychiatrist. His previous community psychiatrist had retired.

The notes made by this new psychiatrist included:

- Mr F lived alone in his flat for two and a half years.
- Sees his son every two weeks.
- Enjoys the internet and music but has little social life.
- Has done little exercise for five years.
- Feels slow on his meds.
- Was on depot Paliperidone 50 every five weeks. Mr F complained of side effects, and this led to him not doing any exercise.
- Mr F denied a history of non-compliance but said if he was not on a CTO, he would not take his depot.

The assessing consultant noted he thought the risks of relapse were low and decided to discharge the community treatment order on 14/08/17. Follow up was to continue and then he would consider oral medication.[7]

[7] It seems inevitable that this point would be reached. The safety net may have been not doing both (i.e., CTO and meds). The report author wondered if the best approach would have been change medication to oral but to remain on a CTO so it could be established that he would self-medicate as prescribed. The independent psychiatrist reflected "This might have been a better option although once he was off depot it was going to be difficult to check medication compliance with oral treatment

One month later, Mr F and the same consultant psychiatrist discussed medication at length, resulting in the decision to continue his depot injection. Mr F was disappointed in this outcome. Taking longer intervals between injections was offered as an option, but Mr F was unwilling to accept that outcome also. The consultant determined that depot was the only option available but would consider changing to oral medication once Mr F had recommenced sertraline and that it had demonstrably achieved stability.

A salient excerpt from the clinical record states:
Mr F "described that he continued to have anxiety which is long standing when he is out and about in crowded places and avoids socialising. Feels people are watching and talking about him when he's in the community, visits mother regularly. Not much motivation to do things because of depot injection, asked about the risk of stopping meds he said his anxiety and paranoid [sic] could get worse. Said he would engage with the team and take oral meds. [The] [community psychiatric nurse] said she would liaise with GP surgery. [They] informed [that Mr F] was not picking up his Sertraline. [He] said he had not gone because he used to get it delivered to his house and he did not like going to GP as he felt anxious"[8].

In the first week of November, Mr F's GP wrote to the community consultant psychiatrist alerting him to the fact that Mr F's depot was three-weeks overdue, and that Mr F did not want it. Mr F had asked for Risperidone and the GP had prescribed this as an alternative. It should be noted that as Mr F was no longer on a community treatment order, denying his request for oral medication was no longer an option.

By 17 November Mr F had not attended at his GP surgery for further Risperidone. On this day he would have run out of the medication with which he had been provided. The clinical record states, "this demonstrates his ongoing poor concordance with medical treatment".

On 29 November, Mr F reported to his community consultant psychiatrist that Risperidone did not work for him and that he wished to try Aripiprazole. This request was approved.

Fourteen months leading to the incident of violent assault with intent to wound

On 17 January 2018, six weeks after Aripiprazole was commenced, Mr F was not available for a scheduled home visit.

On 21 March 2018, a further eight weeks later, the community psychiatric nurse was unable to confirm with the GP surgery whether Mr F was collecting his medication.

On 4 April 2018, successful contact with Mr F was achieved. He reported that Aripiprazole was much better than the depot injections he had previously received. At this care contact, Mr F was also introduced to his new care coordinator and arrangements were made for a follow up medical assessment. However, Mr F did

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as he would not be observed taking it. The new consultant did not feel the criteria for continuing a CTO were met so was then obliged to go for the least restrictive option"

[8] Excerpt from internal investigation report written by Professor J Shaw

not attend this session which was scheduled for 18 April. He also did not attend on 24 May 2018.
Contact was not achieved until 18 June when he was assessed by his new care coordinator. At this meeting no concerns were noted.

On 1 July 2018, the care coordinator again achieved successful contact with Mr F, and he was noted to be taking his medications. The clinical records also note that Mr F confirmed to this professional that he had not taken illicit drugs for many years and did not drink alcohol.

The following day he was assessed by his consultant psychiatrist. The record included the following information:

- No mood problems.
- No change in sleep or appetite.
- Lives on his own but mother has significant input. She tends to cook for him.
- No debts, no alcohol use, no illicit drug use.
- No recent problems with the law.
- No evidence of psychosis.
- On Aripiprazole and Sertraline.
- Mr F's care would be stepped down to the community clinics in the near future.

Between July 2018 and December 2018, the clinical records recorded a period of stability for Mr F, with reasonable compliance with medication and regular contact with his mother. Mr F's request that there was to be no contact with his family remained.

This presentation of stability continued until the day of the incident on 30 March 2019.

5 Findings

This section of the report sets out an overview of the findings arrived at by the original investigator, Professor J Shaw, who was also independent of South West Yorkshire Partnership NHS Trust.

For each key finding, the CUK team has set out commentary outlining the extent to which the team agrees or does not agree with the original findings. There is no element where CUK's own independent assessment materially differs from that of the independent clinician commissioned by the Trust. This is a reassuring finding.

The findings of the NHS England commissioned independent team were arrived at by a constructive review of:

- Mr F's clinical records
- Professor Shaw's report
- A constructive critique of the relevant policies and procedures in place at the Trust when Mr F was in receipt of care and management (see appendix 1)

5.1 Mr F's diagnosis

Mr F had a diagnosis of Schizophrenia. This remains his diagnosis and there is no disagreement in this regard.

5.2 Risk Assessment and Risk Management

Trust policies and procedures of relevance to Mr F's risk assessment and risk management:

At the time Mr F was in receipt of care and treatment from the Trust its risk assessment policy was called 'Clinical Risk Assessment, Management and Training Policy'. It was due for updating in 2019, but this was extended to January 2020 on 3 October 2019. This was again extended to October 2020 because of the pressures caused by the national pandemic. At the time the CUK independent review was conducted, the organisation was aware the Trust had already revised its risk management approach, completely changing its historical approach which had become too unwieldy and ultimately non-functional.

Mr F's care and management was therefore benchmarked against the Royal College of Psychiatrists standards as these represent the best practice standards all NHS providers should deliver.

Relevant historical knowledge about Mr F's risks

Mr F was subject to a risk assessment on 21 May 2013 following referral to forensic services at HMP Leeds where he had been remanded on charges related to three burglaries. He had no psychiatric history at this time, but his family were concerned he was becoming paranoid and delusional. At the start of the assessment, severe mental illness was considered and subsequently confirmed as Paranoid Schizophrenia. The primary reason for his referral was violent behaviour.

In 2013, interrogation of the police national computer revealed he had incurred 20 convictions for 38 offences between 1995 and 2013 (a period of 18 years). The offences comprised:

- Six driving offences
- Eight offences of theft and burglary
- Seven drug related offences
- 15 offences relating to the court (i.e., breaches of orders)

In addition, he had two convictions for offences against a person, namely Assault Occasioning Actual Bodily Harm (AOABH). One occurred in 1996 and one in 2011 for an offence of battery against his partner.[9] The context of the first incident was Mr F, alongside an accomplice, assaulted a man while he was sitting in his car. Mr F broke the victim's arm with a piece of wood. The defence provided was that the assaulted individual had been picking on Mr F's friend.
Regarding the second incident (2011), the context given was that his partner had arrived at Mr F's flat to pick up their son. He got into the car with her and attacked her by grabbing her face, neck, and hair. Minor physical injuries were sustained.

The risk assessment also notes that, when first admitted to the forensic centre, he was verbally hostile and threatened to kill staff. His presentation changed once he was prescribed and administered psychotropic medication. He was noted to have become 'far more relaxed and amenable'.

The assessment also noted that individuals who knew Mr F well reported a volatile nature and a propensity to make others feel intimidated.

This 2013 risk assessment identifies a history of serious substance misuse. Drugs used included cannabis from the age of 14, and heroin and crack cocaine in his early 20s. There was some evidence suggesting the use of class A drugs prior to this.

The assessment conducted up to and including 2013 retained its relevancy between 2014 – 26 March 2019.

In addition to Professor J Shaw's evaluation of the above risk assessment and associated risk management, two independent clinicians were asked to review these assessments on behalf of CUK and the author of this report. These clinicians have substantive experience of general adult mental health services in the community. Their considered opinions offer a valuable counterbalance to Professor Shaw's forensic perspective. The considerations of all three professionals are similar, representing a triangulated consideration of care.

[9] Author's note - This incident though reveals the capability for violence and harm. However not to the extent that homicide would have been a concern. The independent psychiatrist concurs.

5.2.1 Areas where the patient record demonstrated compliance with good practice in risk assessment and management principles as set down by the Royal College of Psychiatrists[10]

The clinical records make clear that Mr F's risks were well documented and understood, up to and including the time he was discharged from the low secure mental health service and its community service to general adult services.

Then, between 2016 and 2017, the reluctance of the general adult community team to rescind Mr F's community treatment order demonstrates sustained awareness of the significant risk presented by his potential disengagement from the team and non-compliance with his medication. The records indicate an awareness that avoiding rescinding the community treatment order was a non-viable option. The team's approach of encouraging Mr F to demonstrate stability and responsibility, as suggested in the records, is indicative of their understanding that careful control and optimisation of the community treatment order in place was necessary to embed healthy behaviours in Mr F.
Mr F reported openly that, had he not been subject to a community treatment order, it was unlikely he would have remained compliant with any treatment plan. This conviction softened and disappeared in 2017.

Excluding a brief period of sporadic contact with Mr F toward the end of 2017 and early 2018, the community mental health records also reveal a reasonable level of testing for substance misuse, and that alcohol and illicit drug usage were regular features of clinical conversations with Mr F.

The independent nurse assessing the report on behalf of CUK was tasked with assessing the risk management practice detailed in the clinical record. This was to be evaluated against compliance with expected standards.
The independent nurse listed the following:

- Risk management must be built on recognition of the service user's strengths and should emphasise recovery. In the case of Mr F, this is demonstrated by the assessments leading to and planning for Mr F to step down from forensic services to the assertive outreach team, and then to the general adult community mental health team. This expectation was also exhibited by the short time he spent receiving the support of the assertive outreach team.
- Awareness that risk cannot be eliminated, yet can be assessed, managed, or mitigated. The level 2 Sainsbury's risk assessment conducted on 19 March and 18 September 2013 clearly demonstrates a comprehensive assessment of the risks posed by Mr F. It identifies the following risk management activities:
  Positive Risk-Taking Options (and support needed)
  - When appropriate, consider the introduction of section 17 leave.

  Opportunities for Risk Minimisation (including risk mitigating/protective factors):

[10] https://www.gov.uk/government/publications/assessing-and-managing-risk-in-mental-health-services
https://www.rcpsych.ac.uk/members/supporting-you/assessing-and-managing-risk-of-patients-causing-harm?searchTerms=risk%20management

- Currently detained under section 37 MHA

Relapse Indicators/Relapse 'Signatures' (for example, inability to sleep, substance misuse)

- Social isolation, lowering of mood, disengagement from MDT
- Expressing bizarre ideation
- Concerns raised by [family/social circles]

Contingency Plan (Actions required to reduce risk of crisis situations developing)

- Currently an inpatient
- Increased level of nursing observations
- Reconsider use of leave

Crisis Plan (Short-Term Crisis Management Options):

- PRN medication
- Verbal de-escalation and use of other approved MAV techniques
- Increased level of nursing observations

Long-Term Risk Management Options

- Continued engagement with mental health services
- Mental health awareness education for Mr F and family
- Depot medication to improve concordance with medication regime

Responsibilities for Actions (including timescale and/or dates)

- Multidisciplinary

Similarly, in January 2016, the Sainsbury's Level 2 risk assessment was comprehensively completed with the following risk management plan.

Positive Risk-Taking Options (and support needed)

- When appropriate, consider the introduction of section 17 leave.

Opportunities for Risk Minimisation (including risk mitigating/protective factors):

- Has a good relationship with his care team, fully concordant with treatment, says he understands the effects of illicit substances on his mental health and has remained drug free since release, drug tests all negative.

Relapse Indicators/Relapse 'Signatures' (for example, inability to sleep, substance misuse)

- Social isolation, lowering of mood, disengagement from MDT
- Expressing bizarre ideation
- Isolative behaviour, preoccupation with physics etc
- Concerns raised from [close family/relationships]
- Evidence of substance misuse

Contingency Plan (Actions required to reduce risk of crisis situations developing)

- Contact care team during office hours, SPA out of hours, consider early assessment under MHA if evidence of deterioration.
- Visit in twos if known to be disturbed and consider early involvement of criminal justice system.

Crisis Plan (Short-Term Crisis Management Options):

- Involve care team to facilitate assessment of risk
- Medical review
- Use of criminal justice services as appropriate
- Do not visit alone if known to be disturbed

Long-Term Risk Management Options

- Continued engagement with Mental health services
- Depot medication

Responsibilities for Actions (including timescale and/or dates)

- Multidisciplinary

The February 2017 Risk Assessment appears to have been copied and pasted from a 2014 and a 2016 assessment as it identifies the date and time for the next review as 27/10/2014. Furthermore, the various risk management plans are an exact replica of those written in 2016.

The level 1 Sainsbury Risk Assessments of 27 January 2016, 1 February 2017, and 22 December 2017 contain no narrative descriptions, only a series of tick boxes.

However, the comprehensive assessment completed on 1 February 2017 provides reasonable detail, including:

- A significant degree of non-engagement with scheduled appointments
- A persistent reluctance in Mr F to engage with the mental health service and to share anything meaningful regarding his well being
- His continued practice of meeting professionals at his mother's home and not his own residence
- No discernible signs of relapse

This document also sets down a comprehensive overview of Mr F's forensic history. It also included a 'strengths and risks' section, last noted to have been completed on 22 December 2017 when he remained on a community treatment order.

There were helpful headings in this section of the comprehensive assessment document, including:

- Main potential risks and risk indicators
- Circumstances that might increase the identified risks
- Actions taken to manage risk
- Protective factors, strengths, skills, and abilities
- Positive coping-strategies and problem-solving abilities
- Supportive relationships
- Engagement with services

There was no narrative set out under any heading. However, the heading 'service user views and goals' states, "[Mr F] is insightful currently into his illness and fully understands the need for continued support, he decided not to

appeal against his CTO and does not attend hearings so far. Pleasant and co-operative during home visits."

- Mr F's records indicate that, until his community consultant retired in 2016, the community team had taken a cautious approach to his many requests that his community treatment order be rescinded. This is particularly clear given the context of his stated belief that he only complied with his mental health medication plan and maintained contact with mental health services because of the community treatment order in place. His candid articulation that he might disengage with services if the community treatment order were removed supports the appropriateness of this caution and the deferment of this decision for as long as possible. Maintaining the community treatment plan in the longer term would not have been viable for mental health services. The circumstances of its imposition (i.e., transfer into forensic services from the prison population) were unique. Had he not required a secure placement because of his conviction, it is unlikely that a psychiatrist working with the general adult population in the community would have instituted this based on the circumstances of Mr F's crime and criminal conviction. Furthermore, by the time the community treatment order was removed, Mr F had altered his position to one of confirming treatment compliance, as opposed to unwavering adherence to non-compliance. The decision to rescind it was reasonable.

- The assessment and management of Mr F's forensic past: Mr F's forensic history makes concerning reading for most lay persons; however, in the context of violent crime and dangerous behaviours, Mr F's forensic history did not convey a blatant risk of harm to others. It would have been a sizable leap in analysis to consider him a homicide risk. Divergence from his mental health care plan and medication carried a predictable risk that he would revert to previous behaviour patterns, including class A drug usage.

- A collaborative approach to risk management was particularly evident within the community forensic team

5.1.2 Areas where the CUK independent clinicians considered practice did not meet the standards expected

- As previously noted, the risk assessment model in use at the Trust at the time, and its associated paperwork, were completed alongside care programme approach documents and medical care plans, leading to fragmented information that was not easy to access in a coherent manner. Moreover, the risk assessment format used was quite complex and the practice of cutting and pasting information between documents over several years resulted in inaccuracies and some confusion.
- The main area in terms of risk assessment, where the CUK independent team and the Trust's own independent investigator considered a significant deviation from documented standards of practice, occurred in relation to crisis and contingency planning. The plans lacked the expected level of detail and consisted only of contact numbers for within working hours and outside of

working hours (this is available to all patients routinely). No early warning signs were documented, nor any specific agreed actions should the patient's mental health deteriorate.

- The lack of access to Mr F's home by the mental health team: All assessments were conducted at the home of Mr F's mother. There is no evidence in the records of any enquiry with Mr F about this, or why he did not want professionals visiting his home. Given his substance misuse history, not addressing or trying to address this was an obstacle to achieving a more complete insight into how he was living and coping with life. However, testimony from Mr F's family confirms that no family member was allowed into his home either. This was normal for Mr F. On the balance of probabilities, persistence by mental health professionals on this point was unlikely to have produced a different result.
- The lack of engagement with Mr F's mother and sisters: Mr F did not give consent for the mental health teams to divulge information about him to his mother, except in exceptional circumstances. However, she was frequently present when he met his health professionals in her home and constituted a key element of his support network. Offering her an assessment of her needs for support, within the context of his care package and her role in supporting him, would have been good practice. A conversation between the author of this report and Mr F's sister revealed that Mr F's mother would have welcomed this. Her own experience of a relative with a mental illness had been difficult. Supporting her son with his mental illness was upsetting and traumatic for her. Mr F's sister also reported not always knowing who to call if concerned. Acknowledging Mr F's right to privacy can limit the persons with whom health professionals can share information. But this does not prevent the provision of accessible and responsive routes for family members and concerned others to communicate with mental health services. This point was also identified by Professor J Shaw in her analysis and is a finding shared by several other independent investigations in the Trust following homicide events.

5.3 Mental health care, management, and treatment

This subsection will focus on the medication management for Mr F and his care planning, including adherence to the care programme approach.

5.3.1 Medication management

A review of Mr F's clinical records and conversation with his sister revealed an ambivalence towards mental health medication. Mr F was never convinced that he required this. Non-compliance with prescribed medication was therefore a tangible risk for Mr F. For these reasons, the cautious approach taken by general adult mental health services to rescinding Mr F's community treatment order was a sensible approach. It provided the vehicle for maintaining medication compliance and via depot injection, ensuring nothing was left to chance.

At the point the community treatment order was rescinded it was only a matter of time before Mr F would request switching from depot to oral medication. It is the independent perspective of the psychiatrist providing clinical advice to CUK that,

"at some point, a trial of a CTO would be inevitable within a CMHT setting. Particularly in someone who is asking to reduce contact with the team, change/reduce/swap to oral medication I don't think it's possible to continue to justify a CTO in the absence of a very significant risk history. In this case, the RC can't point to a previous history of relapse when the medication/CTO has been discontinued because the patient has never had the opportunity to try this option. I'm not saying the CTO would need to be discontinued at an early stage, but I can understand why at some point Mr F would have been taken off his CTO".

Regarding the type of depot Mr F was prescribed and the subsequent oral medication of Aripiprazole, the clinical advisors have no criticism. Neither did Professor Shaw criticise this aspect of Mr F's management. The choice of Aripiprazole was reasonable in view of its side-effect profile after Mr F complained of stiffness on Risperidone (he had also previously had a dystonic reaction with Clopixol).

Regarding the care team's efforts to assess medication compliance and risk: This was not an issue while Mr F was on depot medication and on a community treatment order. However, these safeguards ceased in 2017. Achieving a robust assessment of this is hampered by sparce recordkeeping. Nevertheless, there are records that show Mr F's then consultant psychiatrist discussing the risk of stopping medication with Mr F on 30 October 2017 while, from time to time, the care coordinator records mention checking medication compliance. There is also evidence of checking with the GP about issuing Mr F with prescriptions, and on 15 January 2019 Mr F was escorted to collect his prescription.

Between November 2017 and April 2018 there is a significant gap in Mr F's care regarding contact visits and oversight. Although changes in medication may not have been indicated, the CUK team would have expected evidence of a greater degree of clinical concern about him than is evidenced by the clinical record. Mr F had stopped his depot medication in the Autumn of 2017. This gap in contact was remedied in April 2018, when monthly outpatient contact was reinstated (see next sub-section about Care Planning).

The clinical team, on a justifiable risk management basis, could over this time have considered seeking information from Mr Fs family, particularly his mother. We know from speaking with her daughter that Mr F's mother took every opportunity to invite her son to her home, providing meals and wider family contact. She would have been a good source of information regarding the wellbeing of her son, and it would have created a vehicle for her to raise any concerns she may have had about his wellbeing.

Technically, initiating a doorstep challenge at Mr F's registered address would have been a reasonable intervention. However, because he never invited health professionals or his family to his home it is uncertain whether such a strategy would have been successful.

From April 2018, the clinical notes, though brief, show that Mr F was asked about medication compliance at these appointments and was supported in obtaining his script from his GP surgery in January 2019. Checks were also made with Mr F's GP

regarding his collection of prescriptions. This activity reflects the expected standard of practice in mental health services where there are concerns around medication compliance.

5.3.2 Care planning

Overall, both sets of independent assessors (Professor Shaw and the CUK team) consider that Mr F received a reasonable standard of care and management from the Trust. The gap in risk management and contingency planning is already highlighted in the section on risk management, as is the notable absence of family engagement.

However, in terms of frequency of contact and the way the mental health professionals tried to engage with Mr F, this was reasonable. Monthly contact with this type of service user, one who was assessed as stable, was in line with practice expectations. Furthermore, when Mr F did not attend his appointments, there is a consistent pattern of follow up with him about this and appointments are re-scheduled.

The independent analysis[11] of Mr F's clinical records shows his engagement with any plan initiated by mental health teams was limited. This low to no engagement on behalf of Mr F is something that was unsurprising to his family. They believe Mr F did not accept his mental health illness and preferred to maintain a strict code of privacy. He refused to divulge his private thoughts or reveal challenges he was experiencing to health professionals or his family.

The CUK independent team have no criticism of the care plan for Mr F. Once Mr F's community treatment order was rescinded, he was free to engage or to not engage. There were no indications that he lacked capacity to make his own decisions, regardless of whether they were wise decisions. CUK's independent consultant psychiatrist is of the view that the clinical team did well to try and follow up with Mr F as often as they did (except between November 2017 and April 2018), and to have achieved the level of contact with him that they did.

5.4 The community treatment order

Although the matter of the community treatment order is mentioned at several points in this report, the seriousness of the outcome has compelled the CUK team to create a dedicated section in this report so that the findings of both independent parties can be considered.

Professor Shaw's report stated:
Treatment
"The CTO was rescinded in August 2017. There had previously been consideration of rescinding the CTO, but it had been maintained because there were concerns about possible non-compliance with medication, disengagement from the team within the context of a history of violence. On 24/08/15 it was noted that 'Without CTO he said he was likely to stop meds and relapse and there was a high risk of

[11] By Professor Shaw and CUK

aggression' and in a Report for Manager's Hearing, [the psychiatrist] noted 'seems to have good insight into his illness, accepts the need for treatment but blames depot for lethargy and poor motivation, without CTO there would be a likelihood of stopping medication with high risk or relapse, is too early to discharge from CTO'.

"On 25/09/17, [Mr F] denied a history of non-compliance but said if he wasn't on a CTO, he wouldn't take his depot. On 23/09/13 [the] clinical psychologist said [Mr F's] coping style is one of independence not relying on others; it is exacerbated when he is unwell. It is likely that if he were to recognise the first symptoms of mental ill health, he would be unlikely to talk to a professional. He was also unwilling to accept that he may become unwell again. Risk to others lies in his criminal activity and violence. Criminal activity is more likely if he does not have a range of pro-social activities and contact with others, he gets bored and wants a buzz and gets involved in drug misuse. The risk of violence is increased if unwell and likely to make paranoid interpretations of other's behaviour. [The clinical psychologist] noted that [Mr F's] limited reliance on others and sense of shame about his illness will complicate attempts to prevent future relapse.

"The CTO was rescinded because he was symptom free and compliant with treatment. This was in keeping with Mental Health Act Code of Practice Guidance which indicates that the least restrictive option in relation to care should be pursued. In my opinion, the rescinding of the CTO should have been accompanied by a review of risk and the risk management plan[12]. In view of previous concerns about compliance, the team should have ensured that their subsequent monitoring of [Mr F's] care was sufficient to establish any change in presentation. This should have included contact with the family to give them clear guidance on how to liaise with services if they had concerns."

The CUK team agree with Professor Shaw's consideration about the community treatment order and concur with her opinion that a more robust risk management and crisis intervention plan should have been formulated. Inclusion of Mr F's family should also have been part of this plan. It was essential that they were aware of this for their own safety and wellbeing, alongside their wish to support Mr F and optimise his wellbeing.

Good practice is to construct risk management plans and crisis intervention in partnership with the service user. In this case, all the indications are that Mr F would not have participated in this on anything other than a superficial level.

[12] The evidence gathered by the original investigation team was destroyed, and frontline staff can no longer recall why their practice standards were not as they should have been. CUK knows from previous cases reviewed at this Trust that the style of documentation used was an impediment to accurate record keeping. The Trust has now completely re-designed this so documenting risk assessment is easier to accomplish, and easier to review and track.

5.5 Family engagement

The clinical records, family testimony, and Professor Shaw's report make clear that Mr F did not want his family included in conversations and discussions, and expressly withheld his consent for information sharing except at a superficial level when he met mental health professionals at his mother's home.

It is difficult for clinical professionals to effectively communicate with family members under these conditions. Indeed, they are not empowered to divulge anything about the patient except in specific, high-risk situations, none of which were in evidence in Mr Fs chronology.

Nevertheless, Mr F had all his home visits at his mother's home, and she was recognised as pivotal to the clinical team's ability to meet with and assess Mr F's wellbeing in a home setting. This means that:

- She should have been aware of, and involved in, the design of the risk relapse prevention plan and the crisis intervention plan if symptoms indicative of relapse materialised. Mr F's mother would have been an individual who would have recognised if her son was becoming unwell and could (and would) have acted as an alarm raiser.
- The clinical team should have ensured that Mr F's mother knew how to make effective contact with the team if she was concerned about the mental health wellbeing of her son at any point. Testimony from his sister is that she was not confident about this.
- The mother of Mr F was entitled to both an assessment of her own needs, and an understanding of how the mental health team could support her in being an effective support to her son while also attending to her own health needs. Previous experiences caring for someone else with a mental illness added to the emotional stress she experienced in supporting her son[13].

6.5.1 Engagement of Mr F's family after the 2019 incident

Although Mr F's mother and sister were interviewed by Professor Shaw as part of the initial investigation, at no time did they:

- Receive a copy of the interview/meeting notes made
- Hear about Professor Shaw's interim findings
- Have opportunity to comment on the interim findings report

Furthermore, Mr F's sister told the report author that she had, on multiple occasions, sought information on the progress of the Trust's initial investigation and what support her brother was currently receiving in prison, without avail. Testimony provided by Mr F to his sister had concerned her that he was not receiving the necessary medication or the input of a mental health team while incarcerated.

Mr F's sister has since been updated on these matters because of this independent process.

[13] See section 7 of this report. The Trust recognises that engagement with supportive family members, friends, and Carers must improve. Section 7 sets down the Trust's three primary commitments to those supporting a service user.

6 Summary of identified learning opportunities and improvements made

Professor Shaw's 2019 report stated:
"Care and service delivery issues are areas of practice within the Trust that may not be working in accordance with either local or national policy expectation. Although they may not have a direct link or contribution to the outcome of the incident, care and service delivery issues need to be drawn to the attention of the Trust in order for lessons to be identified and the subsequent improvements to services made."

The two main areas for improvement identified by Professor Shaw were:

- Risk Assessment and contingency planning, including:
  - The accuracy of risk assessment documentation in terms of relevant historical context, contemporary information, and key dates.
  - The depth of risk contingency plans and crisis intervention plans, especially where it is known and predictable that a significant but necessary change in a care plan may diminish the engagement of the service user with the mental health service and/or their medication.
  - The engagement of involved family members (carers and close social support network) in ensuring the risk assessment and management plan is comprehensively informed. This is particularly the case when a family is willing to provide information.

- Family engagement:
  - A service user's reluctance for mental health professionals to share information with those who are providing meaningful input and support does not preclude, firstly, the service from engaging with those individuals to hear what information they wish to share or, secondly, to ensure that they are aware of who to call for assistance/help both in normal working hours and outside of normal working hours.

The CUK team concur and have nothing further to add to these two main learning points.

At the time of writing this report, the CUK team are satisfied that the Trust has completely re-designed its approach to risk assessment. Based on CUK's review and assessment of the new approach as part of a different independent investigation it conducted at the Trust, CUK is satisfied that the revised approach can deliver the standards required. Importantly, the revised approach has the support of frontline clinicians who are expected to work with it. It is not yet clear, however, whether the application of the new approach is delivering what was hoped for in terms of best practice. This must be tested via structured audit.

Regarding how families are engaged and listened to when they form part of a service users' support network, the new clinical risk policy for the Trust now makes clearer the distinction between information sharing (which requires service user consent) and information receiving (i.e., from family and other community members who know the service user) which does not require the service users' consent.

Regarding meaningful family involvement and communication after serious incidents, such as this, the Trust has put together a business case for a family liaison officer role. This business case has been approved.

Mr F's sister has agreed to sit on the interview panel and the interim assistant director of nursing, quality and professions is currently working with recruitment and HR to arrange for the sign off of the job description.

Note: CUK recommends that the Trust draws on the principles of Restorative Justice and restorative processes in shaping the job profile, and includes the competencies of its family liaison officers. It should not, in CUK's view, replicate the police model, which is for an entirely different purpose than what is required in the NHS after incidents of harm.

The Trust has also developed a clear and well designed information leaflet for family, friends, and carers of service users. The three commitments it has published are:

1: We will work with you as a partner
This means we will:

- Listen to what you say and communicate clearly with you without jargon
- Respect your role as a carer and trust that you are the expert in the support of the person who uses our services
- Work with you to overcome barriers to giving support and sharing information and respect carer and patient confidentiality

2: We will support you to get help and assistance when you need it
This means we will:

- Respond in a timely way to your needs especially during time of crisis
- Signpost you to relevant information and advice
- Provide support which is tailored to suit your personal needs
- Have a 'whole family' approach to supporting carers, recognising the needs of young carers

3: We will train our staff to be aware of carers' needs
This means we will:

- Ensure our staff can identify carers and recognise their role as partners
- Enable our staff to respond quickly and flexibly
- Involve our staff in developing information and support for carers

CUK anticipates the Trust will measure its performance against these commitments going forward.

Regarding additional learning reflections: There was one point where Mr F expressed concerns about his then girlfriend (2015). He had previously assaulted a previous girlfriend in 2011. No safeguarding concerns were identified or acted on in 2015. Now the independent review team would expect a safeguarding response as the Trust has implemented an educational programme for its staff regarding domestic abuse and staffs' responsibilities about this. The reviewed risk assessment tool is also more robust and more likely to enable contemporary awareness of such

issues, unlike the risk assessment tool utilised at the time Mr F was a service user with the Trust.

7 Outstanding actions/recommendations required

The Trust can show that it has acted on all the action points set down in its action plan constructed following its own internal investigation. The Trust's new approach to risk assessment, FIRM, is intended to address all the risk management practice and documentation concerns highlighted by its own investigation, this independent investigation, and other investigations (internal and independent).
The recommendations below seek to address what CUK considers to be outstanding issues, and/or the need for auditable assurance that the actions already taken have delivered the improvements they were designed to achieve.

Recommendation 1:
What is required:
Where a service user is actively supported by a carer/family member or close friend, and those individuals are relied on by the service user for their wellbeing and stability, the care team must provide the opportunity for those individuals to share information with the care team on an 'as needed' basis. The service user must be aware of this facility and its necessity. They must be reassured that the care team will not divulge information they hold about the service user with friends/family without the express consent of the service user. Reliably achieving this situation requires service users, families, and frontline practitioners to engage and participate in the process design so that it works, and for the culture change necessary to ensure its success is brought about.

Why must this be achieved?
To alleviate the perception of, and experience of, isolation among those individuals providing essential support to a service user, and to provide them with an easily accessible conduit for communication when anxious about the service user's wellbeing and/or presentation, including risk-based behaviours.

To reduce the risk of:

- The care team being unaware of information that will support the delivery of a safe and effective plan of care, risk management, and risk response plan.
- Family members, friends, and service users being let down by Mental Health Services because of a lack of openness to hear and respond to shared information.

Recommendation 2:
What is required: The Trust is tasked with designing an audit approach that enables it to test the impact of improvements it has already implemented. The key areas that must be tested are:

- the impact of FIRM
- the new approach to risk assessment, risk management and safety planning
- how all care teams communicate and engage with families and carers of service users

Such an audit must embrace the principles of systems analysis and include a systems wide assessment. The following activities are suggested:

- Focus groups of professionals, service users and families
- Peer review of record keeping, assessing content and quality of what is written
- Individual exploratory conversations (interviews) to explore in-depth the experience of staff, patients, and families particularly:

    - Design of risk reduction / safety plans and service user and family involvement
    - The confidence families have to contact a service user's care team
    - The ease with which the family/carers of a service user can contact the care team
    - The responsiveness of the care team as experienced by the family/carer

Why must this be achieved?
Too frequently in the NHS, well intended safety improvement activities are implemented and their success is not tested. This has resulted in a lack of tangible safety improvement despite significant resource being invested in trying to achieve it. It is therefore imperative that the Trust quickly implements enduring systems capable of verifying that the intended improvements are achieved and sustained.

To reduce the risk of:
Avoidable repetition of the concerns raised by this independent process and the Trust's own internal investigation.

Recommendation 3
It is commendable that the Trust is developing the role of a family liaison officer to work with families and be a named point of contact through an incident investigation process. However, CUK recommends that the Trust ensures it embraces the principles of restorative practice after harm into the family liaison officer role, and seeks the advice and input of emerging thought leaders in these fields, along with registered practitioners and facilitators in restorative practice, before finalising its approach.

Why is this recommended:
Many Trusts embrace a police model of family liaison officer for family and victim support in the NHS. However, good practice requires more than this, as is made clear in the Patient Safety Incident Response Framework. The purpose of this recommendation is to support the Trust in meeting its commitments and to facilitate it in achieving best practice in how it works with and supports families after harm.

To reduce the risk of:
The Trusts good intentions and much needed investments in this area falling short of what is required.

8 Conclusions

This is a tragic case that has had a lifelong impact on the lives of the victim's family, Mr F's family, and Mr F himself. There are no indications that the violent act that occurred was influenced by Mr F's mental health disorder, nor by any act or omission by those responsible for the delivery of his mental health care.

It is possible that, had Mr F remained on a community treatment order and depot injection, a different outcome may have transpired, but such an analysis is mere speculation. The decision to rescind Mr F's community treatment order was undertaken after a reasonable period of community treatment and a cautionary approach by the community mental health professionals involved. Its termination was only a matter of time. Retaining it indefinitely was not a viable option based on Mr F's stability in the community and his articulation nearer to the time of rescinding the community treatment order that he would comply with his treatment plan.

That he quickly wanted to move from depot to oral medication soon after was predictable.

The lack of robust contingency planning for when he disengaged with mental health services and/or his prescribed medication is the most significant criticism of his care. It is made by both the Trust's own independent investigator and the independent CUK team commissioned by NHS England.

However, even if such a plan been in place, in the weeks leading to the incident there were no indications that he was relapsing. The incident that occurred also had the hallmarks of premeditation, having followed a previous attack on the victim by the service user weeks prior to his death.

The second criticism was the lack of proactive engagement with Mr F's family. There were opportunities to achieve this without breaching any duty of confidentiality to Mr F. The delivery of a reasonable standard of family engagement would not have prevented the incident that occurred. However, it would have enabled the family to feel valued in their role as part of Mr F's support package.

The report author, the independent consultant psychiatrist, and the independent community matron extend their condolences to the victim's family.

9 Appendices

Appendix 1: Relevant policies and procedures pertinent to the care and management of Mr F

- Carers Commitment (2018)
- Clinical Risk assessment policy 2017 – 2020
- Creative Minds strategy – working with Carers (2011 – 2016)
- Enhanced Care standard operating procedure (2016)
- Functions of Hospital Mangers in relation to community treatment orders