



IMPROVEMENT THROUGH INVESTIGATION

**Independent investigation into the care and treatment of
Mr L**

A report for
NHS England, North Region

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1 Introduction

On 9 June 2011, Mr L stabbed and killed his partner (Ms Y). He pleaded guilty to murder and was sentenced to life imprisonment with a minimum of 12 years.

He had three brief episodes of care with South West Yorkshire Partnership NHS Foundation Trust.

1.1 Background to the independent investigation

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr L.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the healthcare provided that directly caused an incident but it will often find things that could have been done better.

The Chief Executive of South West Yorkshire Partnership NHS Foundation Trust commissioned an internal trust investigation into the care and treatment of Mr L. The Trust investigation team made 12 recommendations. An action plan was developed to take forward them forward.

1.2 Overview of the Trust

South West Yorkshire Partnership NHS Foundation Trust provides community, mental health and learning disability services to the people of Barnsley, Calderdale, Kirklees and Wakefield. The Trust also provides some medium secure (forensic) services to the whole of Yorkshire and the Humber.

2 Terms of reference

The terms of reference for the independent investigation, set by NHS England, North Regional Team, in consultation with South West Yorkshire NHS Foundation Trust are as set out below.

- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan.
- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service users' first contact with services to the time of the offence.
- Review the appropriateness of the treatment of the service users in the light of any identified health and social care needs, identifying areas of good practice and areas of concern.
- Examine whether safeguarding issues were identified and the appropriate safeguarding protocols were subsequently applied.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others.
- Examine the patient's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Involve the families of both the victim and the perpetrator as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the investigation team that includes measurable and sustainable recommendations.
- Assist NHS England in undertaking a brief post-investigation evaluation.

3 Approach of the independent investigation

The investigation team (referred to in this report as “we”) comprised Chris Brougham, senior investigator, and Dr Junais Puthiyarackal, consultant psychiatrist. Biographies for the team are given in appendix A.

We examined a range of national benchmarks, including National Institute for Health and Care Excellence (NICE) guidance and good practice guidance. We also examined trust documents, including policies and procedures, the serious untoward incident investigation report and supplementary information such as the action plan and records of meetings with staff.

Mr L gave his written consent for us to access his medical and other records for the purposes of the investigation. We met Mr L at the outset of the investigation to explain the nature of our work and to inform him that the commissioners of the investigation would probably publish the report in some form. Mr L was given the opportunity to read a draft of this report before it was finalised.

A representative from NHS England, North Regional Team wrote to the victim’s family informing them of the independent investigation.

We met with the victim’s mother at the beginning of the investigation to share the terms of reference with her. We also met with her at the end of the investigation to share our findings and recommendations. We tried to make contact with the victim’s father but were unable to locate him.

We contacted Mr L’s mother to share the terms of reference with her but she declined to contribute to the investigation. We respect her wishes.

We interviewed staff only where we found a gap in information or an area that required clarification or to find out what developments had taken place in the Trust since this incident.

We interviewed the following staff:

- Director of Nursing, Clinical Governance and Safety;
- Clinical Lead for Crisis Resolution/Home Treatment Team (CRHT);
- Pathway Manager for CRHT;
- Care Programme Approach (CPA) Manager;
- Assistant Director of Nursing (Safeguarding);
- Head of Service (Kirklees);
- Director of Corporate Development; and
- Head of Involvement and Inclusion.

We also held two focus groups with staff from the following teams:

- Single Point of Access;
- Intensive Home-based Treatment;
- Community Therapies Pathway;

- Care Management Pathway;
- Acute Care Pathway;
- Dual Diagnosis Service; and
- Crisis Resolution Service.

We developed a chronology outlining Mr L's care and treatment. We then analysed all the evidence we received, and drew our findings from this analysis. Our recommendations address these findings.

Derek Mechen, a partner at Verita, peer-reviewed this report.

4 Executive summary and recommendations

NHS England, North Regional Team commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr L, a mental health service-user.

The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

4.1 The incident

On 9 June 2011 Mr L stabbed and killed his partner (Ms Y). He was charged with and found guilty of murder.

4.2 Overview of care and treatment

Mr L had three brief episodes of care with South West Yorkshire Partnership NHS Foundation Trust.

In August 2002, Mr L was admitted to an acute mental health ward for eight days. He was discharged but failed to attend subsequent outpatient appointments. He was therefore discharged back to the care of his GP. This was in line with practice guidance that was in place at the time.

In September 2007, Mr L was referred to mental health services by his GP. He was assessed by a consultant psychiatrist and referred to primary care counselling. This action was appropriate given Mr L's presentation.

In December 2010, Mr L was admitted to an acute mental health ward for three days. He was discharged with an agreement that the Crisis Resolution Home Treatment Team (CRHT) would follow him up. This was in line with the practice guidance in place at the time.

4.3 Overall conclusions

The care and treatment offered to Mr L was generally of a good standard although there were some missed opportunities. The first was that Mr L was not screened for, or offered, treatment for his substance misuse during the third episode of care. Although we do not think that not referring Mr L to substance misuse services changed the course of events with respect to the incident, we do feel that Mr L should have had the opportunity to access these services and may have benefited from treatment for his substance misuse.

The Trust was unaware that Mr L had an extensive criminal history. This is significant because Mr L had previously been arrested for assaulting Ms Y and for an earlier assault on a former girlfriend. Although staff asked about his criminal history, they did not seek any corroborative evidence from anyone else including his family, girlfriend or the police. If the clinical team had obtained this information as part of the risk assessment process, it might have prompted a discussion about whether there was a need for a safeguarding referral.

These issues have already been identified in the Trust's internal investigation report. There is evidence that all the recommendations have been put in place and signed off. In view of this we have not made any further recommendations in relation to CPA, risk or referral to substance misuse services.

Staff told us that further integration of electronic record systems between the local authority and the Trust would be helpful. This would improve the efficiency of administration and provide the Trust with advance warning of safeguarding issues.

In view of this we have made a recommendation for improvement.

4.4 Recommendation

The Trust should consider the options available to refine and develop its electronic record systems and thereby ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

5 Chronology of care and treatment

Mr L's parents separated when he was young and he remained with his mother. He achieved eight GCSEs and left school at the age of 17 to work in his stepfather's garage. His mother and stepfather then emigrated and he went to live with his father. He took a job in another garage but had problems with work colleagues. He subsequently became unemployed.

Mr L received three separate brief episodes of care and treatment from South West Yorkshire Partnership NHS Foundation Trust. The details of these are set out below.

5.1 First episode of care and treatment:

Mr L attended A&E in Huddersfield on 27 August 2002. He presented as being angry, suicidal, paranoid, and experiencing auditory and visual hallucinations.

He was admitted informally to an adult mental health inpatient ward in Calderdale. This was managed by South West Yorkshire Partnership NHS Foundation Trust.

Mr L disclosed that in the previous few days he had attempted suicide by cutting his wrists and jumping onto a moving car. He also said he had wrecked his house. The police were aware of the incidents.

Mr L reported that he had been abusing alcohol and cannabis for the previous few months.

Mr L was discharged from hospital to the home of his then girlfriend, Ms C, on 4 September 2002. He was offered an assessment by the drug and alcohol team that same day but declined. He was given contact details for the team and advised to reconsider his decision.

On 17 September 2002, Mr L attended an outpatient appointment and was seen by a psychiatrist. He said that he continued to binge-drink at weekends and smoked cannabis several times a week. The psychiatrist gave Mr L contact details again for drug and alcohol services and urged Mr L to attend their services.

A further outpatient appointment was made for Mr L to attend the outpatient clinic on 15 October 2002. He failed to attend so the Trust sent him another appointment for 12 November 2002.

Mr L also failed to attend this outpatient appointment. The Trust informed Mr L's GP in writing that no further appointments would be sent unless the GP requested another one.

5.2 Second episode of care and treatment:

On 27 September 2007, Mr L was referred by his GP to a consultant psychiatrist at the Trust. Mr L complained of a seven-month history of low mood, crying, anxiety, sleeplessness and feelings of paranoia.

Mr L's GP had prescribed Mr L antidepressants in February 2007 but he failed to return for follow-up appointments until August 2007. Mr L was restarted on antidepressants but declined to be referred to psychiatry services at that time.

Mr L eventually agreed to being seen by mental health services. On 19 October 2007 he was assessed by a consultant psychiatrist, who felt that Mr L was depressed but not psychotic and that he had had good insight into his own condition. The consultant psychiatrist wrote to Mr L's GP on 22 October 2007 to ask him to refer Mr L for primary care counselling.

5.3 Third episode of care and treatment:

On 7 December 2010 Mr L attended A&E with his partner Ms Y (the victim). He was assessed by a community psychiatric nurse (CPN) from the Kirklees CRHT. The CPN carried out a mental health assessment and a level 1 Sainsbury's risk assessment¹. These were completed and documented on RiO². The CPN recorded that Mr L "did not disclose" whether he had a forensic history.

Records show that Mr L complained of hearing voices for the previous 24 hours, of not sleeping well and of being anxious, agitated and paranoid.

Mr L was admitted to an inpatient ward at Calderdale adult mental health unit on an informal basis because there were no beds available at St Luke's Hospital, which was in his catchment area. He told staff that he had been using amphetamines for three days. He said that he heard voices all the time but when he used amphetamines the voices got worse. Mr L was placed on level 4 observations (general observations).

A senior house officer³ (SHO) carried out a physical and mental health assessment. Mr L indicated that he had felt persecuted for the last few weeks. The SHO made a provisional diagnosis of acute psychotic reaction, possibly drug-induced.

The management plan was to:

- carry out a comprehensive assessment when Mr L's mental state allowed; and
- for him to be assessed by a senior medical colleague the following morning.

¹ The Sainsbury risk assessment is a tool for documenting the assessment and management of clinical risks in mental health services.

² RiO is the computer system used within South West Yorkshire Partnership NHS Foundation Trust.

³ A junior doctor undertaking training.

The clinical records show that Mr L continued to be extremely anxious, paranoid and agitated, believing that people were going to enter the ward to harm him. Mr L settled after being given medication.

On 8 December 2010, an occupational therapist assessed Mr L, who was then encouraged to undertake ward-based activities. The multidisciplinary team (MDT) review was held on the same day. The MDT made the decision to encourage Mr L to remain on the ward for a further 24 hours and refer him to Huddersfield CRHT in order that he could be supported after discharge from hospital.

A ward nurse assessed Mr L. Records show that Mr L was suspicious and guarded. He told the nurse that he was still wary of others, but did not believe that people were going to kill him. He said that he continued to hear voices but they were not as intense as previously. Mr L said his mood was due to the use of amphetamines that he had taken three days earlier, adding that this was the first time he had used drugs in a long time. Records show that Mr L denied any thoughts of self-harming or hurting others, and agreed to remain on the ward informally hoping for discharge the following day.

The night report shows that Mr L was relaxed at the beginning of the night shift but became more suspicious as the evening wore on. He was worried about being persecuted and sought reassurance about the fire exits on the ward.

On 9 December 2010 Mr L reported to nurses that he felt much better since admission. He discussed a plan to get back into employment following redundancy the previous year. Mr L was hopeful that he would find employment and was keen to resume contact with his eldest son. Records show that there was no evidence of low mood or psychosis.

On 10 December 2010 Mr L told staff that his thoughts were clear and that he had not heard voices during the past day. He said he no longer felt paranoid or suspicious. He had no thoughts of harming himself or anyone else.

Mr L was assessed by a CPN from the Calderdale CRHT on behalf of the Kirklees CRHT (Mr L's catchment area) regarding the possibility of home treatment. Mr L's girlfriend (Ms Y) was also present at the assessment.

During this assessment Mr L denied any psychosis and attributed his recent mental health problems to the amphetamines he had taken. He said he would not take any more as it was not a pleasant experience. He denied any thoughts of harming himself or others. He said he was hoping to be discharged from the ward that day. His girlfriend said that he was back to his normal self and that she was happy for him to be discharged home. A CPN explained the role of the CRHT but Mr L, the CPN and Ms Y agreed that ongoing home treatment was not needed at that time.

An MDT review took place on 10 December. The management plan was that Mr L should be:

- discharged with antipsychotic medication, which he would take for three days if required; and
- referred to Huddersfield CRHT (for the purpose of seven-day follow-up) following his discharge from the ward.

Mr L was discharged from inpatient care on 10 December 2010.

On 11 December a member of staff from the Kirklees CRHT tried to contact Mr L to carry out the seven-day follow-up (as previously agreed) but he was not at home.

A member of staff from the CRHT contacted the ward to try to obtain a telephone contact number for Mr L. The ward staff were unable to provide the number because Mr L had been discharged and his paperwork had been sent for filing.

On 12 December 2010, a member of the Kirklees CRHT visited Mr L's house to carry out the follow-up. There was no response so the member of staff posted a card asking Mr L to contact the team to arrange another appointment.

On 17 December 2010, a senior practitioner with the Kirklees CRHT reviewed Mr L's case in his absence. The CRHT had still not been able to contact Mr L, so in line with the existing practice guidance he was discharged from its care. The team sent a letter to Mr L's GP outlining the details of his recent admission and contact with services.

6 Issues arising

In the followings sections provide our comments on and analysis of the issues in relation to the care and treatment of Mr L that we have identified as part of our investigation.

The first area that we focus on is a review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies from Mr L's first contact with services to the time of the offence.

We consider the following issues:

- the formulation of his diagnosis and care pathway;
- safeguarding, risk assessment and risk management;
- the CPA;
- predictability and preventability;
- the adequacy of the Trust's internal investigation, its findings, recommendations and action plan; and
- the progress that the Trust has made in implementing the action plan.

7 Formulation of diagnosis and pathway of care

In this section we examine whether due consideration was given to Mr L's diagnosis and whether he was in the right pathway of care.

7.1 Background

Mr L was admitted to an acute inpatient ward in August 2002 and stayed there for eight days. He presented with paranoid delusions and auditory hallucinations, including behaviour which was suggestive of him responding to hallucinations. He was diagnosed with mental and behavioural problems due to alcohol and cannabis abuse. The records show that prior to this admission he reported having tried to commit suicide by cutting his wrist. He also told staff that he had jumped onto a moving car and smashed the windscreen with his fist. He reported that he had been abusing alcohol and cannabis for a few months.

Mr L settled on the ward during this first episode of care. He received alcohol detoxification and was discharged from hospital. He was offered an assessment by the drug and alcohol team on the same day but he declined this. He was given contact details of the drug and alcohol team and advised to reconsider his decision to decline. He was discharged from the mental health services in November 2002 following his failure to attend two outpatient appointments.

In October 2007 Mr L was referred to mental health services by his GP. Mr L was assessed by a consultant psychiatrist, who noted that Mr L appeared to be depressed but not psychotic so he suggested a referral for primary care counselling. The consultant concluded that Mr L did not need support from mental health services at this point.

In December 2010 Mr L attended A&E. His records show that he was extremely paranoid and suspicious. He was experiencing auditory hallucinations of both a male and a female voice. He said the voices were coming through the wall, telling him that they were going to kill him and so he felt he needed to get a gun to protect himself. He also complained of poor sleep and concentration for the past month. Records show that he smoked cannabis and had been taking amphetamines for the past few years. He admitted to having taken amphetamines during a party at his home a few days prior to his admission to hospital.

He was admitted to a mental health unit for three days and quickly settled on the ward. He was discharged from the ward with the support of the CRHT. He was diagnosed at the time of discharge with substance-induced psychosis. He was not on any regular antipsychotic medication at the time of discharge.

The CRHT had difficulties in engaging with Mr L following his discharge from the ward. It was unable to contact him on several occasions. A member of staff from the CRHT asked the ward for a contact number but his records had gone for filing. He was subsequently discharged from the care of the CRHT by a senior practitioner. The consultant psychiatrist from the team wrote to Mr L's GP outlining the details of

Mr L's contact with the service and the reasons for his discharge. Mr L had no further contact with the mental health services.

7.2 Analysis

Mr L was diagnosed with substance-induced psychosis during his third episode of care. He showed signs of florid psychosis. The decision to admit him for further assessment was the right course of action. However, following admission to hospital no screening for drug use was carried out; neither was there any evidence to show that he was referred or offered treatment for his substance misuse. A detailed assessment of his drug use by the specialist services and a motivation to change would have been an appropriate management plan, given that he needed admission to hospital after becoming floridly psychotic subsequent to taking amphetamines. It appears that his psychotic symptoms resolved quickly. The decision to discharge him with CRHT support is a standard practice in current psychiatric settings.

There is evidence in the notes to show that the CRHT tried to make contact with Mr L several times before making a decision to discharge him from its care.

The Trust outlined in its own investigation that staff should obtain contact information from the service user prior to discharge. We comment on the progress of the recommendation in section 11.

7.3 Findings

The diagnosis of substance-induced psychosis was correct given the nature of Mr L's presentation.

His admission to an acute inpatient ward (first episode of care) for assessment was the right course of action given his presentation.

Mr L's care and treatment (admission, and the offer of a referral to the drug and alcohol team during the first episode of care) were appropriate given his presentation.

A referral to primary care counselling in the second episode of care was appropriate given that Mr L's presentation did not include any psychotic symptoms.

An admission to hospital and the offer of follow-up by the Trust's CRHT was the right course of action in the third episode of care.

Mr L could have benefited from drug screening and being referred to or offered treatment for his substance misuse in the third episode of care.

8 Safeguarding, risk assessment and risk management

The Kirklees Safer Stronger Communities Partnership Board convened a Domestic Homicide Review (DHR) panel in June 2011 and made the decision that a review should be carried out, since there were lessons to be learnt from the case in respect of Mr L's mental health history and services provided.

The Home Office advised that a full DHR should be undertaken as the case met the criteria set out in paragraph 3.8 of the guidance due to the escalation of Mr L's violence towards partners across three relationships.

A DHR was commissioned in August 2012 by Kirklees Safer Stronger Communities Partnership Board in line with the expectations of *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2011*. This guidance is issued as statutory guidance under section 9(3) of the *Domestic Violence, Crime and Adults Act 2004*.

A DHR report into the death of Ms Y (identified as adult A in the report) was published in February 2013. We do not seek to repeat the full details of this report but it is useful to note the detail of Mr L's criminal history.

The DHR report outlines that, unbeknown to the Trust, Mr L had an extensive criminal history which commenced in 1995. Nineteen arrests were recorded by the police, six of which related to assault. One of these assaults was against Ms Y in January 2009 and another was on a former partner of Mr L in January 2007.

The clinical risk management tool developed by the Sainsbury Centre in 2000 advises NHS trusts that, in order to assess risk accurately, information must be gathered from relevant parties to build up an accurate picture. The parties include:

- the patient;
- carers;
- friends;
- relatives;
- other team members/other teams;
- other statutory or voluntary sector mental health agencies; and
- police, probation, courts.

Risk assessment is an integral part of the assessment and care planning process, and risk assessment requirements are described in both the Trust's CPA policy and procedure document and in the *Clinical Risk Assessment Management and Training Policy*. The principles of trust policy are in keeping with the Department of Health's national policy, *Refocusing the Care Programme Approach: Policy and Positive Practice Guidance March 2008*, and its 2006 guidance on risk assessment.

Part of the Trust's risk assessment documentation for Mr L during his stay in hospital in his third episode of care outlines that Mr L denied any intention to harm others, but he did report that he was fearful for his life and felt that he would act appropriately to defend himself. It is also documented in the notes that he had become violent in the

past but that he refused to divulge any details to staff. Records show that he spent a month on remand for criminal damage/assault, received an antisocial behaviour order and carried out community work as part of his sentence.

8.1 Comment

Considering this history and Mr L's use of stimulant drugs, the ward staff should have attempted to get further details of his risk history by speaking to his family, his girlfriend, his GP and the police.

8.2 Finding

There is no evidence in the notes to suggest that a detailed risk assessment was carried out while Mr L was an inpatient. This has already been recognised in the Trust investigation.

The Trust investigation team recommended increased integration of the risk assessment process throughout the patient journey. It also recommended ensuring that staff routinely seek further relevant forensic information from the police if the service user indicates that he or she has a criminal history and then declines to expand on this information. We comment further about the Trust's progress on the recommendation in relation to risk assessment in section 11.

We heard at interview and in discussion with the focus groups that the Trust now works closely with local authorities to ensure that safeguarding issues are more easily identified and addressed. The Trust has ensured that there is sufficient capacity to support safeguarding. In addition, there is a named doctor for safeguarding along with six clinical safeguarding advisors and eight safeguarding governance coaches. Safeguarding is also an integral process within the risk assessment and CPA process.

In addition to the improvements made, the Trust is currently trialling a new two-stage mental health assessment process which incorporates risk and safeguarding issues.

We also heard that the Trust assures itself of its performance through an annual audit of cases which are open to clinicians to ensure compliance with policy. The Trust offers and ensures that staff attend training in safeguarding at level 1 (basic awareness) and the more advanced level 2. The Trust aims to get ensure that 80% of staff receive training. The training records show that 73% staff have received training to date and that training continues to take place on an ongoing basis.

Staff from the Trust told us that they recognise that safeguarding is an evolving agenda shared between them and local authority colleagues. Significant progress has been made since this incident in improving staff awareness of issues and of joint working with other agencies.

When we met with staff, they told us that further integration of electronic record systems between the local authority and the Trust would help to improve the

efficiency of administration and provide the Trust with advance warning of safeguarding issues.

8.3 Conclusion

The Trust has made significant improvements in taking forward the safeguarding agenda. Further improvements to the electronic record systems would promote even further integration.

8.4 Recommendation

The Trust should consider the options available to refine and develop its electronic record systems and thereby ensure greater integration of systems in regard to safeguarding, care planning and care delivery.

9 The Care Programme Approach

The Trust's CPA policy states that all individuals admitted to inpatient services should be on CPA, and that all service users discharged from hospital will receive seven-day follow-up. This includes those service users who, following a review while receiving inpatient care, have been identified as requiring standard care.

When Mr L was discharged from the ward, staff referred him to the Kirklees CRHT for seven-day follow-up. After the CRHT had made several unsuccessful attempts to contact Mr L, a senior practitioner from the Kirklees CRHT concluded, after having reviewed the risk assessment, inpatient clinical records and admission assessment, that there was nothing to suggest that any further action, such as asking the police to undertake a welfare visit, was necessary. The practitioner consequently decided to discharge Mr L from the service.

9.1 Comment and analysis

The Trust investigation showed that some staff were confused about whether or not Mr L was, or should have been, on CPA when follow-up was required for only seven days.

The Trust's electronic record system, RiO, indicated that Mr L was on CPA and that a CPA discharge meeting had been arranged. There was no date recorded on the system.

The Trust policy on '*did not attend and no access visits*' states that service users should be reviewed on an individual basis and that the subsequent decisions by clinicians should be influenced by an assessment of risk.

In this case, the senior practitioner did review Mr L's risk assessment and clinical records to aid decision-making.

The policy also states that clinicians should seek the support of other members of the multidisciplinary team as appropriate.

Given that Mr L was on CPA, the senior practitioner could have arranged for a review of the decision to discharge him. This would have allowed the team to weigh up the risks and make a joint decision. We do not think that the fact that the decision to discharge Mr L was made by a single practitioner changed the course of events in this case; however, we do consider that a team decision would have been more robust.

The Trust investigation team made recommendations in relation to clarifying the CPA status and discharge arrangements for inpatients who may have had only a brief admission to hospital. We comment on the progress of these recommendations in section 11.

10 Predictability and preventability

In this section we examine whether the incident could have been predicted or prevented.

10.1 Predictability

We would consider that the homicide was predictable if we found that there was evidence from Mr L's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

10.1.1 Finding

Mr L had a criminal history which included 19 arrests. Six of these were related to assault. One of these assaults was against Ms Y in January 2009. The Trust was unaware of these assaults. Despite Mr L's history, he did not present in an aggressive or violent way in any of the episodes of care. Although there were missed opportunities, there is no evidence in the records that his words, actions or behaviour during the time that he received care and treatment from the Trust could have alerted professionals that he might become violent imminently. This homicide was not predictable.

10.2 Preventability

The homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so.

Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

10.2.1 Finding

We found no evidence to indicate that staff had the knowledge, opportunity or means to prevent the homicide from taking place.

We found that there was no specific intervention that the team should have taken to prevent the incident from happening. We found that the homicide was not preventable.

11 The Trust's internal investigation and progress made against the recommendations

The terms of reference for this independent investigation include assessing the quality of the internal investigation and reviewing the Trust's progress in implementing the action plan.

In this section we examine the national guidance and the Trust's incident policy to find out whether the investigation into the care and treatment of Mr L met the requirements set out in them.

11.1 The Trust's internal investigation

The National Patient Safety Agency (NPSA) good practice guidance, *Independent investigation of serious patient safety incidents in mental health services February 2008*, advises that, following a homicide, an internal NHS mental health trust investigation should take place to establish a chronology and identify underlying causes and any further action that needs to be taken. The Trust policy also advises that an internal investigation should take place following a serious incident to see if any lessons can be learnt.

In this case, the DHR subgroup requested that key issues from a domestic homicide perspective be included within the scope of the serious incident investigation report, and that any lessons be fed through to the subgroup for the partnership to inform future practice and partnership working.

The investigation was led by a senior manager who held a trust-wide role and had extensive clinical experience in another area of the Trust. The team also included a consultant psychiatrist working in another service in the Trust and the senior risk portfolio manager.

The investigators selected were sufficiently senior and experienced to undertake the investigation and were independent of the services where Mr L had received services. The incident was investigated using root cause analysis techniques.

The Trust introduced the investigation of incidents, complaint and claims policy in 2008 to promote learning from experience.

The Trust policy states that:

“red (serious) incidents will always be the responsibility of at least the general manager or equivalent. Investigation will usually be by a team with at least the lead investigator independent of the service”.

It also states that:

“Where possible and appropriate the service user, family and/or carers of service users involved in a serious incident will be contacted to establish their possible care and support requirements, and to explain and discuss the investigation process”.

11.2 Terms of reference for the Trust internal investigation

“The terms of reference for the investigation were agreed by the responsible Head of Service and the Director of Nursing, Clinical Governance and Safety.

1. To address the key questions which the DHR subgroup asked to be considered, which particularly relate to information sharing between agencies that may have informed the risk assessments for the service user and their carer, with a key focus on the last inpatient stay and discharge in December 2010, which are:
 - a. How much detail is considered in relation to history taking?
 - Are questions asked as to whether the service users are involved with other services or had contact with other services, e.g. social services, police, voluntary, etc – and if so would these services be contacted for information that might affect the risk assessment?
 - Would further information be sought from agencies if this was thought to be an issue, and would mental health practitioners consider this as part of the assessment of risk and a wider holistic view?
 - b. Are questions asked of the service user and the carer about domestic abuse/violence? Would further information be sought from agencies if this was known to be an issue, and would mental health practitioners consider this as part of the assessment of risk and a wider holistic view?
 - c. What sort of information would they share and what sort of information would they seek in relation to the risk assessment process?
 - d. Discharging into the care of the GP following failure to engage is an issue that has come up in serious case reviews; could this be explored further, considering the responsibilities of professionals?
 - e. What led practitioners to conclude that the service user in this case was a level 1 risk? How and why did they reach this decision?
 - f. If the mental health practitioners had had access to the history and wider level of information, would there have been a different approach?

“To examine:

2. The appropriateness and quality of the treatment, management and decision-making relating to the care of the service user during his last episode of contact with secondary mental health services in December 2010, particularly in respect of:
 - i. assessed health and social care needs;
 - ii. assessed risk of potential harm to self and others;
 - iii. previous psychiatric history, including drug and alcohol use; and
 - iv. previous forensic history.
3. The extent to which the named patient's care corresponded with statutory obligations, relevant national guidance, trust policies, including any team or service operational policies and professional standards and best practice.
4. The extent to which the interface, communication and joint working between all those involved in providing care to meet the service user's mental, social and physical health needs, with particular reference to the CPA, referral assessment and discharge processes.

“To identify:

5. Actions taken following the incident to manage the immediate situation, provide support to those affected and improve services.
6. Any significant care concerns including:
 - a. those that had a direct impact on the outcome of the incident; and
 - b. those that did not have an impact on the outcome of the incident.
7. Any areas of particularly good practice.
8. Findings and learning points for improving systems and services.

“To make:

9. Recommendations to address the findings and learning points, to improve systems and services, and learn lessons for the future.”

The Trust investigation policy and procedures set out a clear process for undertaking a red (serious incident) investigation.

This policy details the responsibilities of the lead investigator and the ways in which staff should be involved in an investigation, including conducting interviews, requesting witness statements and transcribing interviews, which should be signed by the staff member.

11.2.1 Conclusions

The Trust commissioned an internal review into the care and treatment of Mr L, reflecting the terms of reference requested by the DHR subgroup.

The seniority of the investigation team was appropriate given the seriousness of the case.

11.3 The investigative process

The Trust investigation policy and procedures set out a clear process for undertaking a red (serious incident) investigation.

The policy details the responsibilities of the lead investigator and the ways in which staff should be involved in an investigation, including conducting interviews, requesting witness statements and transcribing interviews, which should be signed by the staff member who has been interviewed.

In this case, the investigation team:

- consulted national and trust policies and procedures to use as benchmarks;
- gathered appropriate documentary evidence such as Mr L's clinical records;
- wrote to Mr L and the parents of Ms Y to explain the Trust's internal investigation process and offer a meeting; and
- interviewed relevant staff.

11.3.1 Conclusions

The investigation team carried out the investigation in line with trust procedures.

12 Recommendations and action plans

In this section we examine the Trust's progress in implementing the action plan resulting from their internal investigation.

The report includes twelve recommendations:

1. "The CRHT, or equivalent service, needs to ensure that for people who have ongoing contact with the services there is a system by which following assessment the appropriateness of cluster of the patient and other key decisions are audited and confirmed."
2. "The CRHT, or equivalent staff, should make routine enquiries with A&E staff at the time of the initial assessment to ensure that as full a history and risk profile as possible are obtained."
3. "The Inpatient Service Manager should ensure that the ward MDT understands the requirements for formally completing the required risk assessments and that there are appropriate systems in place to facilitate this."
4. "Staff at each interface or transfer to a new service throughout the patient journey will review the existing assessment and finish the parts not completed previously. This applies to both risk assessment and other parts of the assessment process."
5. "Ward staff should routinely seek further criminal information from the police in relation to inpatients if the person had indicated during assessment that they had a criminal history."
6. "The CRHT should obtain contact and other key information about patients prior to discharge."
7. "Ward staff should provide information on treatment and support options to people who experience drug and alcohol problems as a routine intervention and a system should be in place to support this."
8. "All carers of people on inpatient wards should be given the opportunity to have a discussion with members of the MDT in the absence of the patient."
9. "CPA and discharge policies should be reviewed to clarify the following:
 - CPA status and discharge arrangements for inpatients who have had a brief admission to hospital.
 - The seven-day follow-up process including the rationale for this and how it should be implemented."

10. "Trust policy requirement to complete a level 2 risk assessment for all inpatients should be reviewed with specific reference to short admissions."
11. "Trust policy should be amended to include 'Domestic Abuse Policy – service users' guidance for staff in relation to service users as perpetrators of domestic abuse'."
12. "Information relating to domestic abuse and support should be readily available on the wards for service users and for carers."

An action plan was developed to take forward the recommendations. This is outlined in appendix B.

The action plan clearly sets out the changes in practice, policy and procedure undertaken by the Trust to make improvements.

The Trust has also sent evidence to us demonstrating that the report and the action plan were implemented and monitored by senior service managers and that the findings and lessons learnt were shared with other areas of the Trust through the risk subgroup and the extended executive management team. The action plan and the changes in practice are outlined in Appendix B. The Trust also shared the report and action plan with Kirklees Domestic Homicide Safeguarding Board. The Trust and the Kirklees Domestic Homicide Safeguarding Board formally signed off the report and the action plan confirming that all the actions had been put in place.

12.1.1 Conclusion

From the evidence that we have received, we are satisfied that the recommendations outlined in the Trust's action plan have been actioned to make improvements.

12.2 Post-incident support

In the period following the incident, staff described the tiers of support available. This support starts with fellow members of the same team. In addition, psychological therapies staff have been identified to provide a post-incident debrief for teams and individuals. Individual staff members have access to confidential staff counselling on an ongoing basis.

12.3 Post-incident investigation and governance

The Trust has a comprehensive governance process for the management of serious incidents. The process uses the Datix¹ reporting system to highlight alerts as incidents occur and to track post-incident reviews and monitor subsequent actions. The process and incident reports are overseen by the director of nursing who has responsibility for patient safety. Completed post-incident reports are reviewed by an

¹ Datix is an electronic system for reporting incidents

incident review sub-committee which ensures the completion of the report within nationally agreed timescales, the quality of the report and the appropriateness of the recommendations made.

The Trust supports this process of post-incident review through deployment of four whole-time-equivalent dedicated investigation staff and a programme of training in root cause analysis and report writing. The Trust also delivers a series of learning events to ensure that lessons learnt are disseminated.

The Trust's approach to serious incidents is both comprehensive and systematic and there is evidence that it has refined its processes since this incident.

Team Biographies

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its highest-profile investigations and reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations and individual management reviews. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

Junais Puthiyarackal

Junais qualified as a doctor in 2000. Junais has CCT (Certificate of Completion of Training) in general adult psychiatry and substance misuse psychiatry. He works as a consultant psychiatrist in addictions. Junais chairs the clinical network and is responsible for providing robust clinical governance and risk management in his department. Junais has expertise in managing complex psychiatric cases with the dual problem of mental illness and substance misuse disorder. Junais collaborates in national research projects with experts in the field of addictions. He is also a senior clinical tutor with Hull York Medical School.

Appendix B

South West Yorkshire Partnership NHS Foundation Trust – Action Plan

No	Recommendation	Key Actions	Key Outcome	Agreed Target date	Lead Officer	Progress/Update Rag status	Completion Date	Evidence
South West Yorkshire Partnership NHS Foundation Trust – Updated 14.10.13								
9.	The CRHT, or equivalent service, needs to ensure that for people who have ongoing contact with the services there is a system by which following assessment the appropriateness of cluster of the patient and other key decisions are audited and confirmed.	Kirklees Business Delivery Unit (BDU) All staff, through team meetings and supervision arrangements, to be informed that it is the expectation of the service that: All documentation to be checked on completion for accuracy, with particular regard for the Mental Health Clustering Tool, reiterating need for vigilance when collating documents. This will be monitored through supervision, MDT meetings and CPA.	Service users receive the right level of service, skills knowledge and expertise to meet their individual needs.	August 2012	Team Manager, Kirklees IHBT.	Complete		Communicated through team meeting August 2012. Checking mechanism introduced. Random audit through supervision and meetings. <u>Evidence Received</u>

		Trust wide This recommendation to be shared with all managers of CRHT services in the Trust. This recommendation to be fed into the review of the trust-wide CRHT operational policy process.			Senior portfolio Mgr Risk Practice Governance Lead			
11.	The Inpatient Service Manager should ensure that the ward MDT understands the requirements for formally completing the required risk assessments and that there are appropriate systems in place to facilitate this.	Calderdale Ward staff reminded of importance of risk assessment and need to follow trust policy. Team leaders to discuss with primary nurses in supervision. To review documentation of ward review, ensuring it incorporates evidence, assessment (including risk), formulation and plan on RiO. Following review, develop a system to ensure that MDT discussions are fully reflected and implement the system. Audit the new system 3 months after implementation to ensure there is clear evidence on RiO to	Practitioners understand and appreciate the rationale and requirement for formal risk assessment and the interface with positive outcomes in clinical care. To ensure audit trail of decision-making.	August 2012	Team Leaders Consultant Psychiatrist Ward Manager	Complete		31/10/12 – Staff have been reminded via supervision. 31/10/12 - System to ensure MDT discussions are documented is now in place. To be audited in November 2012. <u>Evidence Received</u>

		support the patient journey.						
12.	Staff at each interface or transfer to a new service throughout the patient journey will review the existing assessment and finish the parts not completed previously. This applies to both risk assessment and other parts of the assessment process.	Kirklees To communicate to the teams the importance of reviewing all assessment documentation at point of referral by or admission to the team to ensure that all essential information, particularly around risk, is built upon and if possible completed by the referring clinician or care coordinator. Practitioners within all teams to record ongoing relevant information throughout the episode	To ensure risk assessment is seen as a dynamic process which is dependent on high-quality, timely information.	August 2012	All Pathway managers	Complete		Communicated to Acute Pathway Team Managers. <u>Evidence Received</u>

		of care. Method of monitor via Care Pathway Calderdale Ensure that staff across services are aware of the need to integrate and build on assessment information.						
13.	Ward staff should routinely seek further criminal information from the police in relation to inpatients if the person had indicated during assessment that they had a criminal history.	Calderdale Provide a named link to the police for the ward so that information about relevant past forensic/criminal history can be sought in the interests of service user, staff and public safety.	Information about a forensic past will inform the clinical risk assessment and enhance understanding of link between clinical presentation and offending behaviour. Information about a criminal past will, where relevant, inform risk assessment and subsequent intervention with regard to public safety.	August 2012	Serious Incident Investigators	Complete		Meeting with the police took place on 10 August. <u>Evidence Received</u> •

14.	CRHT should obtain contact and other key information about patients prior to discharge.	Calderdale Develop a checklist to ensure that accuracy of contact information is checked on a regular basis and particularly at admission and discharge. Audit the checklist after three months of operation to ensure embedded in practice.	Statutory requirement for seven-day follow-up is met	August 2012	Elmdale Ward Clinical Team Manager Clinical Team Manager	Complete	January 2013	31/10/12 – checklist in place. To be audited in November 2012. <u>Evidence Received</u>
15.	Ward staff should provide information on treatment and support options to people who experience drug and alcohol problems as a routine intervention and a system should be in place to support this.	Calderdale To be addressed in review as detailed in 3. System to ensure that there is a record of multidisciplinary plans and how these have been actioned. Audit the new system three months after implementation to ensure there is clear evidence on RiO to support the patient journey complete.	Service users receive information to make informed choices with regard to drugs and alcohol.		Clinical Team Manager	Complete		31/10/12 – system in place. To be audited in November 2012. <u>Evidence Received</u>
16.	All carers of people on inpatient wards should be given the opportunity to	Calderdale Following discussions with carers' support service, agreement has	Carers' needs will be addressed in order to support them in		Clinical Team Manager	Complete	January 2013	Agreement in place.

	have a discussion with members the MDT in the absence of the patient.	been reached that support staff will routinely visit the ward and offer support to carers. Standard has been set that carers will be invited to have a 1:1 meeting with the primary nurse within a week of admission. Audit that the measures above have improved carer experience in three months' time – completed	their roles and to ensure that their needs are being addressed.		Clinical Team Manager			Standard set – to be audited in November 2012. <u>Evidence Received</u>
17.	CPA and discharge policies should be reviewed to clarify: CPA status and discharge arrangements for inpatients who have had a brief admission to hospital. The seven-day follow-up process including the rationale for this and how it should be implemented.	Trustwide The Trust's CPA policy is currently being reviewed and will be approved in August 2012. The recommendations from this report will be acted upon within the review. This will strengthen the understanding of the seven-day follow-up as part of a discharge plan and when it is the only potential contact following discharge from inpatient services. The policy will also link with the Do Not Attend /No access visit policy.	Policy will give clear guidance on seven-day follow-up, discharge, and service users who disengage.		Trust CPA lead	Complete	January 2013	June 2013 – policy was approved August 2013. <u>Evidence Received</u>

18.	Trust policy requirement to complete a level 2 risk assessment for all inpatients should be reviewed with specific reference to short admissions.	Trustwide The level 2 risk assessment will be reviewed within the context of the policy to capture the recommendations as part of the policies review.	The clinical risk management policy and CPA policy will be clear about timeframe requirements for risk assessment.		Trust CPA Lead	Complete	January 2013	Trustwide The level 2 risk assessment will be reviewed within the context of the policy to capture the recommendations as part of the policies review. June 2013 – policy has been updated. <u>Evidence Received</u>
19.	Trust policy should be amended to include 'Domestic Abuse Policy – service users' guidance for staff in relation to service users as perpetrators of domestic abuse'.	Trustwide This issue will be taken to the Adult Safeguarding Trust Action Group for consideration and the outcome of this discussion reported back to the Kirklees and Calderdale Heads of Service/ General Managers	Staff will have clear guidance about their role in recognising and reporting perpetrators of domestic violence.		Trust Vulnerable Adults Lead	Complete		June 2013 – Policy link on intranet says domestic abuse policy service user. Multi-Agency Risk Assessment Conference MARAC briefings have taken place. Policy covers service users who may be perpetrators of abuse. <u>Evidence Received</u>
20.	Information relating to domestic abuse and support should be readily available on the wards for service users and for carers.	Trustwide This issue will be taken to the Adult Safeguarding Trust Action Group for consideration and the outcome of this discussion reported back to the Kirklees and Calderdale Heads of	Information on domestic violence and where to get support will be readily available across the service.		Responsible Director for Safeguarding	Complete		June 2013 – Intranet has guidance for staff – given the size of the organisation, this is the best method. <u>Evidence Sent</u> • Copy of intranet information.

		Service/ General Managers.						• MARAC Briefing. • Email confirmation that DV Information has been uploaded to intranet.
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Acronyms used in report

NICE - The National Institute for Health and Care Excellence

CRHT - Crisis Resolution/Home Treatment Team

CPA - Care Programme Approach

CPN - Community Psychiatric Nurse

SHO - Senior House Officer

MDT - Multidisciplinary Team

DHR - Domestic Homicide Review

NPSA - National Patient Safety Agency

BDU – Business Delivery Unit

MARAC – Multi-agency Risk Assessment Conference