VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr T and Mr U

A report for
NHS England, South Region

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1. Introduction

NHS South of England[1] commissioned Verita to carry out an independent investigation into the care and treatment of Mr T, an ex-mental health service-user, who stabbed and killed Mr U, a mental health service-user on 16 March 2012. Mr T was convicted of murder and jailed for life on 12 November 2012.

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 provision of healthcare that directly caused an incident but it will often find things that could have been done better.

The West Berkshire Locality Director (Berkshire Healthcare NHS Foundation Trust) commissioned an internal investigation into the care and management of Mr T and Mr U. The head of mental health services, West Berkshire carried out the investigation. The trust investigation found areas of practice that needed addressing and made three recommendations.

Verita is a management consultancy that works with regulated organisations to improve their effectiveness and levels of service. It specialises in conducting independent investigations, reviews and inquiries. Tariq Hussain, senior consultant, Andy Nash, mental health and social care consultant and Dr Sian McIver, forensic consultant psychiatrist (together referred to as 'we' from now on) carried out this work. Our biographies appear at the end of this report (appendix A).

1.1 Background to the independent investigation

Mr T received three separate episodes of care from Berkshire Healthcare NHS Foundation Trust. His most recent period of treatment and care was from Newbury Community Mental Health Team (CMHT). He had self-referred to the mental health service on 21 November 2011. He was last seen in February 2012 and discharged into the care of probation and his GP. He was subsequently charged along with two other people with the murder of Mr U.

The victim, Mr U, had a long forensic history and had been in and out of youth offender units and prison since the age of 13. He had also received care and treatment by the trust and was under the care of the Newbury CMHT at the time of the incident. He was also receiving support from Turning Point (a national social care provider) and from probation services.

[1] Following the introduction of the Health and Social Care Bill 2012 on 1 April 2013 the responsibilities of NHS South of England transferred to the newly formed NHS England, South Region. For consistency we have referred to NHS South of England throughout this report as they were the original commissioners of the review.

1.2 Overview of the Trust

Berkshire Healthcare NHS Foundation Trust provides secondary mental health care to people in Berkshire.

Most secondary care services are based in the local community. Many of the people the trust supports are looked after in their own homes so that they can continue to lead active lives in the community while receiving the mental health support they need.

2. Terms of reference

The terms of reference for the independent investigation, set by NHS South of England, in consultation with Berkshire Healthcare NHS Foundation Trust are as set out below.

2.1 The purpose of the investigation

To identify whether there were any aspects of the care which could have been altered or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents occurring.

The overall aim is to identify common risks and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

2.2 Main objectives

- To evaluate the mental health care and treatment including risk assessment and risk management.
- To identify key issues, lessons learnt, recommendations and actions by all directly involved in providing the care plan.
- To assess progress made on the delivery of action plans following the internal investigation.
- To identify lessons and recommendations that has wider implications so that they are disseminated to other services and agencies.
- Identify care or service delivery issues, along with the factors that might have contributed to the incident.

2.3 Terms of reference

- Review the assessment, treatment and care that Mr T and Mr U received from Berkshire Healthcare NHS Foundation Trust.
- Review the care planning and risk assessment policy and procedures.
- Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
- Review the interagency working between the Trust and other agencies and how this influenced the formulation and care plan.
- Review the interagency working between Berkshire Healthcare NHS Foundation Trust, Primary Care, Probation, and substance misuse services, and how this influenced the formulation and care plan.
- Review the documentation and recording of key information.
- Review communication, case management and care delivery.
- To review professional judgement processes and actions and ensure they correspond with statutory obligations, relevant good practice guidance from the Department of Health, and local operational policies (with particular reference to safeguarding).

- Review the Trust's internal investigation of the incident to include timeliness and methodology to identify:
    - if the internal investigation satisfied the terms of reference;
    - if all key issues and lessons have been identified;
    - whether recommendations are appropriate and comprehensive and flow from the lessons learnt;
    - review progress made against the action plan;
    - review processes in place to embed any lessons learnt;
    - conducting a thematic review of the unit's risk assessment, risk management and care planning approaches;
    - testing out the trust investigation's conclusions/findings; and
    - seeking evidence of the implementation of their recommendations.
- Review any communication and work with families of the victim and perpetrator.
- Establish appropriate contacts and communications with family/carers to ensure appropriate engagement with the independent investigation process.

3. Executive summary and recommendations

NHS South of England 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 T an ex-mental health service-user who stabbed and killed Mr U, a mental health service-user on 16 March 2012. Mr T was convicted of murder and jailed for life on 12 November 2012.

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.

We were asked to see if any aspects of the care that could have been altered or prevented the incident. The investigation should also identify areas where improvements to services might be required, which could help prevent similar incidents.

The overall aim of this independent investigation is to identify common risks and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

3.1 The incident

Mr T, a recent ex-service user, along with two others stabbed to death Mr U, another service-user, in Mr U's flat in a supported housing complex.

We interviewed managers, clinical staff and local authority children and families services managers. We learned from them that the incident that led to the death of Mr U was related to a dispute between local groups/families and that Mr U was "in the wrong place at the wrong time".

3.2 Overview of care and treatment

Mr T received three separate episodes of care from Berkshire Healthcare NHS Foundation Trust. His most recent period of treatment and care was from Newbury Community Mental Health Team (CMHT). He had self-referred to the mental health service on 21 November 2011. He was last seen in February 2012 and discharged into the care of probation and his GP. He was subsequently charged along with two other people with the murder of Mr U. The homicide occurred on 16 March 2012.

The victim, Mr U, had a long forensic history. He had been in and out of youth offender units and prison since he was 13. He had also received care and treatment from the trust and was under the care of the Newbury CMHT at the time of the incident. He was also receiving support from Turning Point (a national social care provider) and from probation services.

3.3 Overall conclusions of the independent investigation

We did not find the incident to have been predictable or preventable. We found nothing in Mr T's words, actions or behaviour at the time that could have warned professionals that he might imminently become violent. Mr T did not present in a way that would have indicated that he should have been admitted to hospital. We found other areas of treatment and care that could have been improved.

Our findings and recommendations are listed below.

3.4 Findings

F1 Staff failed to follow the safeguarding procedures when they received information that suggested Mr T's children and possibly his partner were at risk.

F2 The approach taken to risk assessment with Mr T was not in line with national good practice or with the trust's own risk management policy.

F3 Mr T was eligible to be cared for under CPA. This would have ensured a more formal approach to his care and support.

F4 The mental health services were aware that Mr T and his partner had two young children and that she was pregnant. In light of the concerns raised by the local authority children and families service and the probation service, it was wrong for Mr T to be discharged from the mental health service on 6 February 2012.

F5 A multi-agency review of Mr T's care that included the mental health services should have taken place.

F6 In light of our overall assessment of the care of Mr T and Mr U, we conclude that the incident was not related to any mental health issues in either man and that it was the result of criminality. None of Mr T's words, actions or behaviour at the time could have alerted professionals that he was about to become violent. Mr T did not present in a way that would have indicated that he should have been admitted to hospital. The incident was neither predictable nor preventable.

F7 The trust's serious incident investigation and report was inadequate as a means of reviewing the care of Mr T and Mr U. It was also inadequate as a means of learning for the trust.

3.5 Recommendations

R1 The trust should ensure that the work of the short-term team is integrated into the secondary mental health services and its function is clearly understood.

R2 The trust should negotiate with key partners a policy/protocol that sets out when a multi-agency review meeting should be called.

R3 The trust should issue a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested. If a

referral is not to be made a recorded rationale for why must be placed on the patient's notes.

R4 The trust board should commission a report that will provide it with robust evidence of the quality and compliance level of risk assessments.

R5 Senior trust managers should negotiate with senior managers from partner agencies the level of information sharing at Multi Agency Public Protection Arrangement (MAPPA) meetings to ensure it is consistent with national good practice.

R6 The trust should seek agreement with partner agencies for a joint protocol governing when an inter-agency investigation is required and how it should be conducted. This should clearly set out the role of the lead agency and expectations of the other agencies contributing to the investigation. This would not affect individual agency requirements to conduct their own inquiries.

R7 The trust should ensure that a person in a direct line management relationship or in the locality/directorate does not undertake investigations with the service under investigation. An investigation must be conducted by a suitably trained individual who is clear about its role and function.

R8 The trust should develop and implement a strategy for improving record-keeping.

R9 The trust should amend its policy for investigating serious incidents and reporting on them to ensure sufficient challenge and scrutiny are built into the process. The board, including non-executive directors, should receive a full report from all level 5 incidents as well as themed reports. The board should be able to assure itself about the progress of recommendations from all serious incidents.

4. Approach

We gathered documentary evidence, including policies and procedures from the trust, Mr T's trust and GP clinical records as well as the trust's investigation. A list of documents reviewed appears at appendix B.

We interviewed staff. A list appears at appendix C.

NHS South of England sought written consent from Mr T for access to his medical and other records. He did not reply so the trust's Caldicott Guardian agreed to release the records because the investigation was in the public interest.

We wrote to Mr T ask to meet to explain the nature of our investigation and that the commissioners would probably publish the report in some form. He did not respond.

We wrote to Mr T to ask if he wanted an opportunity to comment on a draft of this report. He did not respond.

Mr T's wife had moved away and no contact details were available. We sought Mr U's family contact details from the trust, probation, social services and the coroner but were only able to locate one historical address for Mr U's sister. We received no reply to our letter to her so the investigation proceeded without any family contact.

This report includes chronologies outlining the care and treatment of Mr T and Mr U. Our analysis of the care of Mr T and Mr U appears after each of the chronologies. Further analysis of a number of issues and themes arising from our review follows on from section 8.

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

5. Chronology of Mr T's care and treatment

5.1 Personal history

Mr T was born on 16 November 1989. He went into care after his mother died when he was 12.

Mr T had experienced problems since childhood. These affected his mood and coping skills. He misused drugs and alcohol from the age of 13. He lived with a partner and had two children who were under supervision and support from children and family services.

5.2 Psychiatric history

Mr T received three separate episodes of care from Berkshire Healthcare NHS Foundation Trust.

5.2.1 First episode of care: April 2008 until May 2008

Mr T was first referred to the Newbury CMHT at Berkshire Healthcare NHS Foundation Trust by his GP on 17 April 2008. The referral letter said Mr T was taking a lot of Speed (an illegal drug), was in contact with probation services and was experiencing mental health issues.

The letter said Mr T had a history of self-harm, had taken overdoses and had a tendency to anger.

West Berkshire Young Offenders Team sent offence notes to the CMHT showing that Mr T had previously been arrested for assault and that he was considered a medium risk.

A social worker from the crisis/home treatment team in the Newbury CMHT wrote to Mr T offering an appointment to assess his needs.

A note on the data input sheet said an alert should be put on the system because as Mr T was known to have a history of violence and drug use. Another handwritten note said: "not to be seen alone".

Mr T did not contact the CMHT to make an appointment so the case was closed on 14 May 2008.

5.2.2 Second episode of care: April 2011 until July 2011

Mr T's GP referred him to the CMHT in April 2011 for emotional problems and anxiety. The letter said Mr T had a long history in the care system and a history of alcohol abuse and violence by his father and grandfather.

A community psychiatric nurse (CPN) and a psychotherapist assessed Mr T on 21 June 2011. He told them that he was struggling with his moods, had anxiety and poor self-esteem. Records of the visit show that he was motivated to engage with

services. Mr T and the staff agreed that he would be seen by psychotherapy to explore treatment options. Two further appointments were offered but Mr T did not attend. He was nevertheless engaging with probation services at this time.

Mr T's partner phoned the psychotherapy service in July 2011 expressing concerns about him. She told staff he was experiencing mood swings and thought he should be sectioned under the Mental Health Act. Staff at the psychotherapy service gave her a crisis contact number and told her Mr T would need to contact services himself. Mr T's partner called again expressing concerns. A psychotherapy appointment was offered for 22 July 2011 but Mr T did not attend.

5.2.3 Third episode of care: November 2011 until February 2012

Mr T self-referred into the Common Point of Entry (CPE) service on 21 November 2011. He told staff he had become irritable, withdrawn and felt empty.

He was seen by two community psychiatric nurses. Clinical records note:

> "Mr T has long standing problems since childhood which are still affecting his mood and coping. His pregnant girlfriend and he have 2 young children who are being supported by the Children's team and they are facing eviction as their landlord wishes to sell. This has increased his anxiety, frustration and self-blame."

Mr T told staff that he wanted something done about his moods or he would end up "doing something". The notes say "….however, when questioned there did not seem to be any substance for this and he was calmer when we were able to set up a plan for follow up". The CPN recorded that Mr T should be reviewed by a psychiatrist. Urgent care phone numbers were given by the CPNs to Mr T and his partner.

Mr T was subsequently transferred into Care Pathways (Newbury CMHT) where his needs were identified as social care issues. He was allocated to a social worker to help in relation to benefits, work and accommodation.

Mr T contacted the social worker on 12 December to say he could not attend a planned appointment because he was at the police station. He did not provide details.

The social worker saw Mr T on 13 December. He was cut and bruised following events at the weekend (details unknown). He told her that events from the past had come to the surface. Mr T was distressed, crying and angry. The session was difficult for Mr T. A further appointment was made for 19 December but Mr T did not attend.
Mr T was under probation services. No meetings took place with probation and liaison between CMHT and probation took place through phone calls.

Mr T phoned the social worker on 6 January 2012 to ask about support. The social worker told him he needed to post back a questionnaire for the Newbury Link group[1]. She also said he could drop in and make an appointment at Turning Point[2].

Mr T met the social worker on 10 January 2012. He presented with positive plans to give up drinking alcohol and get on with family life. He acknowledged that he came to the attention of the police when he drank.

Mr T's probation officer contacted the social worker on 24 January 2012 to say that Mr T was engaged with probation services and that his behaviour was chaotic. The CMHT and the probation office agreed that Mr T should remain on the CMHT caseload with a view to discharging him if he did not engage.

Mr T did not contact the CMHT so he was advised to get in touch if he needed support in the future. At this time he was actively engaged with the probation service and awaiting a place on a link psychotherapy group.

A risk assessment completed on 22 November 2011 recorded that Mr T had been sexually and emotionally abused as a child, which was affecting his ability to cope. He, his pregnant partner and two children were facing eviction, which increased his anxiety. The risk assessment recorded that the children had been on the Child Protection Register and were being supported by the local authority children services.

[1] The Newbury Link Group offers a friendly open environment where people can be part of a group which addresses ways of coping more positively with difficulties faced in day to day lives.
[2] Turning Point is a social care provider and also provides a range of drug and alcohol services, helping recovery from addiction.

6. Care co-ordination provided to Mr T

In this section we examine the key areas we identified from the terms of reference. These are:

- provision of services and assessment;
- safeguarding children;
- risk assessment, risk management;
- Care Programme Approach; and
- inter-agency working – with safeguarding and children and families services.

6.1 Summary description of Mr T's psychiatric needs

Mr T had a history of drug and alcohol abuse, he had self-harmed and had overdosed. He had anger problems and had been arrested for assault. He was suffering from anxiety and emotional problems. He had poor self-esteem and mood swings. He had been emotionally and sexually abused as a child. When he self-referred to the CPE service on 21 November 2011 he was withdrawn and felt "empty". A note on the file warned: "not to be seen alone".

6.2 Provision of services and assessment

Mr T was referred for psychotherapy in June 2011. Given his childhood history and current difficulties, this was an appropriate response to his needs. Neither the file, nor staff interviews make clear what the contingency plan was if he did not attend appointments.

A signed handwritten note on file (dated 17 March 2004 and not part of a risk assessment) says "not to be seen alone". The psychotherapist who saw Mr T with a colleague acted on the advice.

Two CPNs assessed Mr T in November 2011 because of his low mood and increased anxiety. They agreed that he needed an assessment by a psychiatrist but no arrangements were made to do this.

The two CPNs told us they thought the most important issue was to get the assessment plan done. They were aware of previous contacts and his forensic history, which they acquired from reviewing his progress notes and other records. They did not speak with the CPN or psychotherapist who had assessed him in June 2011.

They did not know when they interviewed him that a note in the system advised that he should not be interviewed on his own. They told us that an alert button on the electronic patient record system (RiO) could be used to draw attention to such issues. They were reasonably sure that an alert was not in place for this case.

The two CPNs told us they assessed Mr T as mostly needing social support around housing (his landlord had given him notice) and support for his two children and pregnant partner.

Their assessment plan said a referral to a psychiatrist should be made, but Mr T was referred to the short-term team so the referral to the psychiatrist was redundant because his needs had been assessed as mainly social. The CPNs also told us that the short-term team could refer an individual for assessment by a psychiatrist if they felt it necessary or refer back to any of the other teams. Mr T was referred back to his GP who could have dealt with his medication.

6.2.1 Comment

The failure to refer Mr T to a psychiatrist meant that an opportunity for a formal mental health assessment was lost. This may have identified whether Mr T had a personality disorder or a long-standing psychosis. A review by a psychiatrist could have provided a view on whether the referral to the short-term team should have been supplemented by other treatment and support.

Our psychiatric expert noted the lack of a referral to a psychiatrist but added "…the care and treatment received by Mr T was appropriate to his disorder and needs". We support this view but we are concerned that the referral was not followed through. Mr T's history and previous contact with the trust meant that a second opinion from a psychiatrist should have been obtained.

6.3 Safeguarding children

The trust's safeguarding policy says all staff should understand that safeguarding children is everyone's business, and that staff should recognise and know how to respond when children may be at risk. The policy also says that those who work with service-users must be aware of the risk factors to children and consider the implications of an individual service-user's mental health or behaviour on the safety and wellbeing of any children they may come into contact with.

The Children and Families Services told us that Mr T's children were subject to a child protection plan between 25 November 2010 and 5 May 2011 because of concerns in relation to Mr T's addiction to alcohol, mental health issues and domestic violence. The child protection plan was changed to a children-in-need plan in May 2011 because of Mr T's improved relationship with his partner and their having been assessed as caring appropriately for the children.

They continued to be on a children-in-need plan from May 2011 and received advice and support about parenting, relationship, finances and housing. They attended the children's centre regularly with the children and were regularly seen by a health visitor.

We note above that Mr T had a violent history and a forensic record. His partner contacted the mental health service on 5 January 2012, concerned about his behaviour. He had got drunk the night before and she had refused to let him into the house and had called the police, who arrested him. He was making threats of self-harm. The social worker from the short term team told his partner that Mr T should call himself if he needed extra support. We found no record of this information having

been shared with child and families services and the trust's risk assessment was not updated.

6.3.1 Comment

When the mother of Mr T's children phoned with concerns about his behaviour in January 2012 adequate information was not sought from her nor was she given adequate information to allow the risks posed to his children to be fully assessed, managed and communicated to other agencies. She was merely told that he would have to contact the service himself if he wanted extra support.

The children and families services social worker told Mr T's short-term team social worker on 18 January that she was worried about him. He had moved out of the family home because of his tendency to become volatile after drinking and she felt there were increased risks to the children. This phone call was not followed by an update of his assessment to reflect the risk that the children's social worker had just highlighted.

There is no evidence that the reports coming from his partner and the children's social worker about concerns around Mr T's behaviour and mental health were discussed with the trust's safeguarding lead. There is also no evidence that action was taken in accordance with the trust's safeguarding policy and national safeguarding standards.

6.3.2 Comment

Mr T was a violent man with a volatile temper and an alcohol problem. His partner and their children and families services social worker had raised concerns about him. These circumstances clearly called for a referral to the trust's safeguarding leads and a decision about further support to safeguard the children.

A number of possible responses to the potential safeguarding concern about his partner and children were available. They could have included considering whether a safeguarding multi-agency meeting was needed, whether a Mental Health Act assessment was needed and whether a more coordinated approach to his care should have been implemented.

6.3.3 Finding

F1 Staff failed to follow the safeguarding procedures when they received information that suggested Mr T's children and possibly his partner were at risk.

6.4 Risk assessments

The Department of Health's *National best practice guidance in managing risk* (2008) notes that service-users vary in the degree to which they need a formal risk management plan. It also sets out other relevant criteria which we set out below.

- Screening for risk should be part of a routine mental health assessment but is not an end in itself and should, where necessary, lead to further action.
- Some service-users will be identified as a priority for in-depth assessment and intervention as a result of this routine screening, or will identify themselves as in need.
- A second opinion should be sought from specialist services when appropriate, for instance if a service-user has a history of serious violence.

The trust's risk management policy says:

> "… the risk assessment/management process is initiated when a person becomes subject to CPA and/or when they receive specialist mental health care."

6.4.1 Comment

> Mr T had been referred to the trust's short-term team and as a consequence he did not become subject to CPA. Nevertheless, he had received specialist mental health care so he was subject to the trust's risk assessment policy.

Mr T's file contains a document which has a list of six previous convictions for violent offences. Some of this offending appears to involve domestic violence. At least three incidents describe Mr T as seriously violent, such as his hitting his father over the head with a metal bar and stamping on his face. The document lists Mr T's indicators for harm as medium risk. This document does not appear to have been uploaded to RiO and does not appear to have been incorporated into risk assessments.

Mr T was assessed in November 2011 by two CPNs and there is on file a risk assessment. This assessment is undated and unsigned and poorly completed. For example, sections not completed include "Harm to Others", "Harm from Others", "Other Risk Behaviours" and "Factors Affecting Risk".

Mr T's file is quite slim and includes a referral letter dated 13 April 2011 from the GP to the CMHT that sets out a full history of concern and risk. For example, it states:

> "His mother died when he was 12 years old and he has a long history in the care system. He is entangled in historical family issues including substantial alcohol abuse and violence on the part of his father and grandfather."

> "He complains of anxiety and difficulty in coping with emotions which often turn into anger which he finds easier to deal with."

None of this information is included in the risk assessment, even though it would have been easy to access and was recent information. We have seen no evidence that this risk assessment was shared with other agencies.

Following this initial assessment, probation and children and families services contacted the trust to express concerns about Mr T's mental health. This information should have prompted staff to update the risk assessment or undertake a new one in light of information from third parties.

Again, this was in breach of the trust's policy, which states at paragraph 6.2:

> "… assessors also need to listen to and take into account the concerns of non-professionals such as carers, employers, neighbours and the service users themselves."

The record shows that Mr T had a probation officer but no one appears to have checked his criminal record. Paragraph 6.3 of the trust's policy says:

> "All staff conducting risk assessments must be aware of how to obtain details of individual's criminal convictions from the police."

The policy goes on to give details of who to contact in the criminal records office and probation service to do this.

6.4.2 Comment

The trust's policy refers to risk assessment being an essential element of work with the mentally ill. As part of the risk assessment staff should have sought a record of Mr T's criminal record. The risk assessment carried out in November 2011 with Mr T was inadequate and did not seem to feature as any part of the care planning for Mr T.

Staff compliance with good practice and trust policy in regard to risk assessment was weak. We comment on and assess this later in the report when we summarise Mr T's care.

6.4.3 Finding

F2 The approach taken to risk assessment with Mr T was not in line with national good practice or with the trust's own risk management policy.

6.5 Care programme approach

The trust CPA policy states:

> "… the majority of people in receipt of secondary mental health services are likely to be cared for using the CPA."

We set out in appendix D a summary of the national CPA guidance.

Berkshire Healthcare NHS Foundation Trust CPA policy says CPA is applicable to all adults with complex needs – where a multidisciplinary approach is required - in contact with the secondary mental health system. However, its principles apply equally to the care and treatment of younger and older people with mental health problems and to adults with less complex needs.

Two CPNs who assessed Mr T in November 2011 concluded that he needed mainly social support and did not meet the criteria to be placed on CPA.

Documents we reviewed show that Mr T met the criteria for the Care Programme Approach. These included:

- a long history in the care system;
- a history of alcohol abuse;
- experiencing violence from his father and grandfather;
- a history of drug use;
- known to be violent and advised "not to be seen alone";
- problems working with mental health services in the past;
- difficulties parenting and receiving support from the children's team;
- unsettled in his accommodation – and was going to be evicted; and
- contact with probation services.

We cannot say whether Mr T had a mental disorder because he was never assessed by a psychiatrist.

6.5.1 Comment

The decision not to place Mr T on CPA was flawed and did not meet national good practice.

6.5.2 Finding

F3 Mr T was eligible to be cared for under CPA. This would have ensured a more formal approach to his care and support.

6.6 Referral to the short-term team

The trust provides mental health services to those not on CPA but we have seen no guidance or policies relating to criteria for providing services to those who do not fit CPA criteria. Mr T was allocated to a social worker in the short-term team.

The short-term team is a social care team dealing with people who do not meet CPA criteria. This is an unusual model, though not necessarily a wrong model. However, access to psychiatric support appears to have been ad hoc. Mr T's social worker told us:

> "It is [a] very small [team]. We have a couple of social workers. We have other workers like a drug and alcohol worker, the forensic lead, the AMHP [approved mental health practitioner] lead that sit within the team, but primarily I am one of the social workers that do the case work. We take the

> referrals from CPE, we re-triage whether they come to us, whether they will go into our psychology or whether they will go into the longer-term teams. Sometimes we bounce them back if they are not appropriate. We are doing very short term pieces of real social work, which is quite nice again. We work very closely with our colleagues at West Berkshire Council in terms of children safeguarding, adult safeguarding, physical disabilities, learning disabilities. It is all sorts of bits that really don't always fit neatly in secondary mental health."

The Newbury CMHT structure chart (11 September 2013) shows that it has a number of components. These are set out at appendix E.

6.6.1 Comment

> The structure of the service and the pathway for service-users is unclear, with users being potentially dealt with by a number of teams. We have seen no documentation describing how these teams relate to each other. In particular, how the role of the short-term team fits with other teams.

We asked the social worker allocated to Mr T why the short-term team was providing a service to Mr T even though he was not on CPA. She told us:

> "… sometimes people come into us for two or three weeks on the back of a social issue that we resolve quite quickly. We don't really want to label people and get people into the CPA process. It is not appropriate. It is onerous in terms of recording and all other things. We tend not to. If they have had an admission and they have a long and enduring mental health disorder, they are going to need that regular review and care planning and that process that contains that, that is fair enough."

The locality director we interviewed told us:

> "… this short-term team, it evolved because there was a cohort of staff that needed a role and function. Their previous role and function was that they were part of the combined health and social care/home treatment crisis team, so they wanted to retain that element of work. Therefore, they retained their presence in the locality mental health team as a short-term team."

We asked Mr T's allocated social worker how the team was able to access a psychiatrist assessment. She told us:

> "… I would go and discuss with either the patch team consultants or their SHOs and say 'Can you give us a hand?' and 'Can you review this person for us?'."

6.6.2 Comment

> The care of a service-user under CPA is coordinated either through a single professional allocated to them or by an allocated care coordinator, arranging the inputs from a number of different professionals or services. We were told by the short-term team social worker that they did not provide care co-

ordination in a formal CPA way. Mr T was assessed as needing only social care - effectively help with accommodation, benefits and seeking work. This was inappropriate given his known history and his range of needs.

Mr T needed a mental health examination by a psychiatrist to formulate a diagnosis. This was not arranged because Mr T's needs were assessed as primarily social care. The referral to the short-term team served only to confuse matters. A psychiatric assessment would have determined if Mr T had an underlying psychiatric condition.

This is an important omission because a diagnosis might have steered Mr T to a different pathway/service in the trust that might better have met his needs.

6.7 Discharge

Mr T's partner called the mental health service on 5 January 2012, concerned about his volatility, drinking and threats to self-harm. The local authority children's and families social worker contacted the mental health service on 18 January because Mr T was no longer living at home and he had become volatile when drinking excessively. His probation officer also contacted the mental health service on 24 January saying his behaviour was generally chaotic. Mr T was nonetheless discharged on 6 February.

6.7.1 Finding

F4 The mental health services were aware that Mr T and his partner had two young children and that she was pregnant. In light of the concerns raised by the local authority children and families service and the probation service, it was wrong for Mr T to be discharged from the mental health service on 6 February 2012.

6.8 Multi-agency reviews

The local authority children and families service provided us with a summary of their contacts with Mr T and his partner. The information shows a number of reviews attended by Mr T and his partner. The children and families services social worker, probation, and the family health visitor also attended these reviews at various times. The mental health service appears not to have attended. Information from Mr T's allocated mental health social worker is included in the notes at various points.

The last meeting before the incident was on 24 January. It records that CMHT support from Mr T's allocated social worker was ending.

The two CPNs who saw Mr T in November 2011 told us that on reflecting on this case they agreed that a more coordinated approach to the care of Mr T (for example by having a multi-agency planning meeting) might have helped coordinate the various agency inputs. They also agreed that he might have been eligible for a MAPPA referral and so might have been referred into Care Pathways, as opposed to the short-term team.

6.8.1 Comment

There was a fair degree of information sharing and joint meetings between local authority children and families team, probation and health visiting about Mr T and his family. The mental health team were not involved in meetings, but did share information on an ad hoc basis. Mr T's difficulty with anger and his possible mental health issues could have had an impact on the safeguarding arrangements for his partner and children. In these circumstances, a multi-agency review that included mental health service staff was warranted and should have taken place.

6.8.2 Finding

F5 A multi-agency review of Mr T's care that included the mental health services should have taken place.

7. Chronology of Mr U's care and treatment

7.1 Personal history

Mr U was born on 8 December 1974 in East London. He set fire to his house when he was four. He regularly got into fights with teachers at school and starting drinking alcohol and smoking cannabis at nine. He was eventually sent to a local authority boarding school. He was involved in a road accident when he was 15 and he never returned to school. He was given few opportunities for education because he was considered violent.

7.2 Psychiatric history

He was diagnosed with paranoid schizophrenia at the age of 25. This was compounded by his substance misuse. He received treatment from drug and alcohol services in Birmingham.

Mr U had a long criminal history. He had been in and out of youth offender units since he was 13 and in prison for offences ranging from grievous bodily harm to burglary.

Mr U was released from prison in 2004 and received drug rehabilitation. He moved from Birmingham to Newbury to live with his sister and her two children. A consultant liaison psychiatrist from Birmingham wrote to Mr U's GP in Newbury requesting a referral to a psychiatrist.

The Newbury CMHT regularly reviewed him during 2004. He was placed on CPA and was allocated a care coordinator. He also attended Alcoholics Anonymous[1] twice a week. Tensions developed between Mr U and his sister, so he was re-housed and given a one-bed flat.

Mr U continued to receive support from the Newbury mental health services throughout 2006. He married and had a child. Mr U's care coordinator raised concerns about Mr U's violent history. Mr U also developed a fixed idea that the baby was not his. The care coordinator referred the family to the local authority children and families team.

Mr U was admitted to Prospect Park Hospital in Newbury under Section 2 of the Mental Health Act in January 2007. Once he was stabilised, he was discharged on CPA, prescribed anti-psychotic medication and followed up by the CMHT.

Despite follow-up and support from the CMHT, Mr U started back on intravenous drug misuse. He was also charged with burglary. His wife left him, taking his child with her.

[1] Alcoholics Anonymous (AA) is an agency that supports personal recovery and continued sobriety of individual alcoholics.

Mr U received an 18-month prison sentence. He was released in 2010 on a drug rehabilitation order. He was referred back to the Newbury CMHT, was accepted under CPA and allocated to a new care coordinator.

Mr U received regular assessments and support by his care coordinator throughout 2010/11. Mr U continued to misuse drugs and was placed on the heroin substitute programme. He was placed in a supported housing complex with support from Creative Support[1].

Mr U was jailed for a number of burglaries in August 2011.

Mr U was released from prison under a drugs order and tagged in January 2012. He continued to be supported by Newbury CMHT and probation services.

Mr U remained in contact with the probation service in the weeks leading up to his death. He was due to appear in court again to review his drug rehabilitation order because he had not been keeping appointments with probation services as agreed.

[1] A service that provides a range of services including supported living, supported housing and residential care.

8. Care coordination provided to Mr U

In this section we look at the key areas we have identified in the terms of reference in relation to Mr U. These are:

- safeguarding adults;
- risk assessment;
- Care Programme Approach; and
- drug and alcohol services.

8.1 Summary of Mr U's needs

Mr U had a diagnosis of paranoid schizophrenia and had been sectioned under the Mental Health Act. He had a history of drug and alcohol abuse, was violent and had a forensic history. He had been released from prison and was under the care of Newbury CMHT and the probation service. He had regular assessments and support from a care coordinator before his last prison admission.

Many notes relate to Mr U's involvement with mental health services before his imprisonment but only limited notes relate to him after his discharge from prison in 2010. Notes describe visits and community psychiatric nurses' actions on behalf of Mr U with external agencies.

8.2 Safeguarding adults

We discuss in this section whether Mr U met the criteria for being a vulnerable adult. The Department of Health guidance *No secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* defines a vulnerable adult as someone "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."

The trust policy states that people most likely to be assessed as vulnerable are adults who:

- are elderly and frail;
- suffer from mental illness, including dementia;
- have a physical or sensory disability;
- have a learning disability; and
- suffer from a severe and incapacitating physical illness.

A risk assessment completed on 24 November 2011 notes:

> "Mr U has in the past cut his wrists and taken overdoses."

Mr U was seen as vulnerable. Several risk assessment review forms on file note:

> "Mr U is a vulnerable man who has spent most of his adult life in prison and so is quite institutionalised. He is however, quite street wise and is unlikely to be financially exploited. He can easily be led astray by stronger characters."

Mr U's clinical file also contains notes about his violent behaviour – particularly towards police. He was living in low-support accommodation.

8.2.1 Comment

> From our review of Mr U's notes and our interview with his care coordinator we did not assess Mr U as vulnerable in the context of the trust safeguarding adults' criteria. We were not able to interview his care coordinators from 2010 and 2011 because they had left the service.

8.3 CPA

We discuss in this section whether Mr U was managed in line with the trust's CPA guidance.

Dr Sian McIver, consultant psychiatrist and our expert advisor, concludes:

> "Mr U was managed via the CPA process and was allocated a care coordinator with a social work background. This seems an appropriate course of intervention. There is evidence that his care coordinators made strong efforts to remain in touch with him when he was in and out of prison. It is also clear from the correspondence that Mr U was able to elicit care when he wanted support and to ask his care coordinator to do things for him. Mr U was appropriately signposted and encouraged to attend a group programme and the substance misuse service."

8.4 Risk assessments

In respect of risk assessments, our expert concludes:

> "There is evidence that Mr U had regular risk assessments outlining his risk. He demonstrated a consistently low risk of harm from others and only scored positively from this on one occasion in July 2005 when it was noted that he could be easily led."

Mr U's care manager said that he was damaged and chaotic but did not have impaired cognition or capacity. He was aware of his potential and the outcomes of his behaviour. He generally got what he wanted from services and was a "survivor". He continually put himself at risk from his abuse of alcohol and illicit drugs. The major concern of the staff caring for him was his criminality, not his mental state.

8.5 Drug and alcohol services

Mr U was on a drug rehabilitation order on discharge from prison. His clinical file contains no documentation relating to multi-agency discussions or planning between the trust, probation or local drug agencies.

8.5.1 Comment

Mr U had a mental health diagnosis but his main difficulties were his criminality and chaotic lifestyle. He was being supported by probation and living in low-support accommodation.

9. Summary of the mental health care provided to Mr T and Mr U

We found no significant failures in the care delivered to Mr T and Mr U that had a direct or indirect impact of the killing of Mr U. We set out below a number of concluding quotes from our expert forensic consultant psychiatrist. They provide a useful summary of our views on the care of both Mr T and Mr U. She concludes that in respect of Mr T:

> "I think that the type of support offered in terms of him having an allocated social worker as his care co-ordinator, giving due consideration to the appropriateness of psychotherapy, advising him to participate in group work in relation to his difficulties, supporting him in relation to housing needs and debt management as well as giving advice about becoming involved with the substance misuse service were all entirely appropriate."

She identified the weaknesses in the risk assessment in relation to Mr T but concluded that:

> "However I do not feel that there is any evidence that this lack of risk assessment contributed to the homicide which Mr T subsequently went on to commit."

In respect of Mr U, our expert concludes that:

> "The overall care of patient Mr U seems to have been of a good standard. He appears to be a rather chaotic individual and spent much of the time the mental health services were involved with him in prison where his care coordinators made efforts to maintain links with him through correspondence and also continued to offer practical support.
>
> "The extent of his mental health difficulties do not in my view mean that he was particularly vulnerable to others except perhaps in the way the risk assessment mentioned in terms of being easily led. I can find no evidence that he was particularly at risk of being the victim of a violent assault except by virtue of the fact that he potentially mixed in criminal circles given his forensic history. I do not think an opportunity for safeguarding was missed by the team caring for him."

9.1 Overall assessment of predictability and preventability

9.1.1 Finding

F6 In light of our overall assessment of the care of Mr T and Mr U, we conclude that the incident was not related to any mental health issues in either man and that it was the result of criminality. None of Mr T's words, actions or behaviour at the time could have alerted professionals that he was about to become violent. Mr T did not present in a way that would have indicated that he should have been admitted to hospital. The incident was neither predictable nor preventable.

9.1.2 Comment

We do not attribute the incident to any failure in care or organisational systems but a number of areas for improvement have emerged from our review:

- the need for staff to follow the safeguarding procedures more closely and to seek advice whenever there is even a small likelihood of harm to children or vulnerable adults;
- clarity over the role of the short-term team;
- ensuring that if a service-user is recommended to be reviewed by a psychiatrist this should happen;
- the need for multi-agency reviews when a number of different agencies are involved; and
- the need for staff to complete risk assessments more effectively.

9.1.3 Recommendations

R1 The trust should ensure that the work of the short-term team is integrated into the secondary mental health services and its function is clearly understood.

R2 The trust should negotiate with key partners a policy/protocol that sets out when a multi-agency review meeting should be called.

R3 The trust should issue a practice guidance note reminding all staff that a referral for a psychiatric assessment should always be made if requested. If a referral is not to be made a recorded rationale for why must be placed on the patient's notes.

R4 The trust board should commission a report that will provide it with robust evidence of the quality and compliance level of risk assessments.

10. Multi-agency working

Mr T was known to known to the trust, the probation service and children and families services and drug and alcohol services. West Berkshire County Council provides children and families services in the trust's catchment area.

We reviewed information supplied to us by the children and families service. This shows that meetings were held on the following dates:

Date	Attendance	Mental health involvement
3 October 2011	Mother, father, children's centre and social worker	
30 November 2011	Housing, social worker, children's centre, clients	Mr T said he was attending CMHT weekly, seeing short-term team social worker
24 January 2012	Children's centre, probation, CR (unknown), Apologies from health visitor	CMHT social worker notified that support for Mr T was ending

This shows that joint meetings were being held with a number of agencies but that the mental health trust was not involved.

The social worker from the short-term team told us she had regular phone discussions with children and families and with probation but the content of these discussions is not recorded so we do not know their purpose.

10.1 Relationships with local authority children and families service

Senior managers in the children and families service told us that relationships with the trust were "good". They had the usual issues about levels of risk and information sharing, but nothing that could not be resolved by a manager-to-manager phone call. Regular meetings took place between the trust and children and families managers responsible for specific service areas such as child and adolescent mental health services (CAMHS). Staff met at the local safeguarding boards and the children's partnership board. If Mr T posed a risk, they would have expected to be told.

Senior managers confirmed there was no inter-agency protocol for conducting multi-agency inquiries; neither was there a forum for agencies to discuss issues of common concern.

10.2 Relationships with the probation service

We cannot comment on this in detail because our efforts to interview probation staff were unsuccessful. We found evidence of inter-professional sharing of information. Trust staff told us that information was shared case by case, but we cannot comment beyond this. We tried several times without success to arrange interviews with local probation staff involved with Mr T and Mr U and with the local senior area manager.

10.2.1 Comment

Our difficulties in arranging interviews with the probation service may indicate difficulties in joint working but we accept that this is speculation. We comment further on joint working with probation later in this report.

10.3 Joint agency meetings

The trust locality director told us no forum existed where partner agencies (social care, police, and probation) meet to discuss issues.

10.3.1 Comment

Inter-agency work in West Berkshire has many positive aspects. The trust management team reported that MAPPA and safeguarding arrangements worked well and that the relationship with the children and families service was good. Managers we met confirmed this.

The social worker from the short-term team described day-to-day working relationships and information sharing across agencies as good. The psychotherapist who assessed Mr T was aware of his/her responsibility to share information when it related to risk to adults or children. The safeguarding adults policy and risk management policy are comprehensive and acknowledge the need to share information – the policy reminds staff that "mental health services need to think family".

However, the lack of leadership about which agency was to lead on a post-incident multi-agency review was and at the time of our investigation remained problematic. The deputy director of governance told us that no arrangements exist should this become an issue again.

10.4 MAPPA information sharing

Both Mr T and Mr U had been convicted of many offences. The probation manager wrote to us:

> "Between them they have accumulated over 180 offences and over 90 convictions mainly acquisitive crimes interspersed with violent related offences. Between the 3 offenders [the third offender was not in receipt of mental health services] they have entrenched history of substance misuse, mental health issues, history of domestic abuse, poor employment record, poor history of compliance with supervision, high tolerance for criminality, strong affiliation with other criminal associates and extensive periods in prison."

We have seen no evidence that either Mr T or Mr U were the subject of MAPPA discussions. Our expert advises that Mr T would not have been eligible for MAPPA.

A number of staff and managers told us that MAPPA meeting minutes were not circulated. Professionals were not allowed to take notes and had to rely on memory.

We were also told by a number of staff that if you ask you can have the minute of the client you are involved with.

There is a policy (*Multi Agency Public Protection Arrangements (MAPPA), Memorandum of understanding, Thames Valley*) covering the National Probation Service, HM Prison Service and Thames Valley Police (TVP). It is not dated and does not include the trust. Section 4 states:

> "Risk meetings are minuted. These minutes are highly confidential and must not be disclosed other than agreed in the risk management plan or in consultation with the MAPPA co-ordinator."

Newbury CMHT forensic lead wrote to us late in our investigation:

> "I can confirm that I attend the MAPPA meetings, and if I am absent due to leave, X is the person who will step in and attend the MAPPA.
>
> "I can confirm for definite the local information sharing arrangements are as follows:
>
> 1. Minutes are taken at each meeting by the MAPPA Administrator from TVP and are stored securely at the police station. If a person is of interest to us (i.e. they are on our books) then we can request a copy of the minutes to be securely emailed to us where we would store securely. I can confirm that in the past 3 months (since I have been attending) we have not discussed any persons of interest to us so no request made for copy of minutes.
> 2. Any people discussed at the meeting that are of interest to one or more agencies at the MAPPA, will be sent by secure email a copy of the ACTIONS from the meeting. These are not sent to everyone, just to the individual agencies who have actions from the meeting. These are sent to the individual professional within 48 hours of a MAPPA Meeting.
> 3. The Local protocol is due to be discussed at the next MAPPA in January, where all CORE members will be required to sign up to the Local MAPPA arrangements.
>
> "I can confirm that attending MAPPA is a priority and there will always be representation from CMHT."

The children's and families managers told us that attendees at MAPPA meetings were not permitted to record information-only actions for their agency. Meetings were recorded and written minutes taken but not distributed. The MAPPA meeting joint chairs came from probation and the police.

We found considerable confusion and a lack of understanding from both local and trust level managers about the actual processes for sharing MAPPA information. MAPPA is a key safety process in a locality and the level of information-sharing described seems unusual and not consistent with practices in other areas, where minutes are shared with all relevant agencies/professionals.

10.4.1 Recommendation

R5 Senior trust managers should negotiate with senior managers from partner agencies the level of information sharing at MAPPA meetings to ensure it is consistent with national good practice.

11. The trust internal investigation process and report

Our terms of reference as set out in section 2 asks us to review the Trust's internal investigation of the incident to include timeliness and methodology.

11.1 Commissioning of the report and general process/governance

We reviewed the trust's *Adverse events/serious untoward incidents policy (August 2011)* in force at the time of the incident. This sets out clear procedures for establishing and conducting an internal investigation.

However, in this case there was some confusion about the commissioning of the investigation and the nature of what was required. Senior trust managers told us that an investigation into the care of both Mr T and Mr U was to be commissioned by West Berkshire Social Services but following discussions between the police and the director of social services a multi-agency review would be convened by the probation service. This did not take place and we have been unable to find out why.

The probation service conducted its own internal investigation, which it declined to share with partner agencies or with us. Trust senior managers told us that the chief executive of West Berkshire Council formally asked the probation service for a copy of its report but it declined.

We tried several times to meet with the probation officers responsible for the care of Mr T and Mr U but were unsuccessful. We arranged instead to meet with the local area senior manager but the appointment was rearranged once and then cancelled the day before. We sent the local senior probation manager extracts from transcripts of trust managers' interviews. These related to their view of the probation service involvement in the case and in the post-incident review arrangements. We received a written response.

The local senior probation manager told us:

"The report was to highlight some key findings from our internal review to the safer community strategic partners. It was not intended for wider circulation or dissemination.

> "We did not disagree to a multi-agency review … [X] from west berks district council was chasing the Trust as to what the next step would be but did not get a response that indicated a multi-agency review was going to be the next step or that there was an appetite for it.
>
> "Probation was prepared to be part of a multi-agency review; it was not for probation to call for such a review. We undertook an internal review in accordance with NOMS Serious Further Offence procedure, which does not require or call for a multi-agency review. If I recall there were some confusion as to which part within health restructure (taking place at the time) would pick it up. There is a query as to whether such a review will fall under the safeguarding adult SCR remit or within a health review. The restructuring with Health meant that this was not picked up until recently."

Trust senior managers told us no multi-agency protocol existed to provide guidance about when a multi-agency review should take place or the processes for discussion about whether one should be commissioned.

11.1.1 Recommendation

R6 The trust should seek agreement with partner agencies for a joint protocol governing when an inter-agency investigation is required and how it should be conducted. This should clearly set out the role of the lead agency and expectations of the other agencies contributing to the investigation. This would not affect individual agency requirements to conduct their own inquiries.

Probation convened a meeting in which it summarised the outcome of its internal investigation. The trust manager who attended told us that the probation service had accepted that "communication with mental health services could have been better" but had refused to elaborate.

The senior probation manager told us:

> "I did acknowledge in my presentation that the offender manager during the course of the supervision of the case should have taken the opportunity to liaise with mental health services given the offender's history of psychiatric services. In the case of Mr U, we have on record that the CMHT worker contacted the offender manager to advice [sic] that Mr U disclosed use of heroin and had no intention of reporting to his offender manager. There were [sic] certainly on going liaison with CMHT. It must be said that there was little offender manager contact with Mr U between November 2011 and March 2012 because Mr U's supervision was interspersed with a few periods in custody as a remand and convicted prisoner."
>
> "… there were aspects of the offender practice that were below the required standards, this did not have a causal relation to the murder of Mr U and attempted murder of DB.
>
> "The supervision of one or two of these cases was characterised by seeing these offenders as a chaotic, vulnerable individuals primarily in need of support rather than potentially as priority, volatile offenders with underlying capacity for violent behaviour – that is not to say that an offence of great seriousness was predictable."

11.2 The commissioning of the trust's investigation

The trust senior managers told us they were expecting a multi-agency review so their investigation was in effect an individual management review (IMR)[1] rather than a trust serious incident investigation.

The deputy director of governance told us that the power to undertake an internal investigation rested with him. In this case the locality director commissioned the investigation. The head of mental health services was asked to undertake the investigation. In both cases, the people holding these posts were managerially responsible for the services they were investigating. Senior managers told us it was normal for the line manager of a service to commission a member of staff to undertake such an investigation. The locality director told us:

> "Because it is a local issue, as director, I would be commissioning manager and the process would be localised to ensure that the investigation is undertaken."

The trust's *Adverse events and serious untoward incidents policy*, 2011/2013 says:

> "The Governance Team will identify a Commissioning Manager who will normally be the senior person in charge of the area."
>
> "(An investigating officer) will be chosen from the list of those staff who have completed the training."

The head of mental health services, who had been appointed as the investigating officer, told us she had not undertaken training in conducting inquiries of this nature. She had been asked to conduct this investigation because her relatively short time in post (six months) would enable her to be objective.

11.2.1 Comment

Regardless of the skills or knowledge of the commissioning manager or investigating officer there is a procedural integrity in having any investigation undertaken by a manager who is not in a line management relationship with the service being investigated, or even within the locality service. This is important to rebut any possibility of bias and can be important if, for example, a coroner reviewed the report.

Whatever confusion arose about whether this was to be a multi-agency review or not, it was still necessary for the trust to conduct a serious incident investigation by a suitably trained member of staff irrespective of any inter-agency considerations.

[1] These are undertaken as part of a multi-agency review when each agency would conduct a review of their role in the case and an overview report would then be written.

11.2.2 Recommendation

R7 The trust should ensure that a person in a direct line management relationship or in the locality/directorate does not undertake investigations with the service under investigation. An investigation must be conducted by a suitably trained individual who is clear about its role and function.

11.3 The trust's investigation report

The trust investigator interviewed two members of staff. Mr T was assessed by a psychotherapist and a nurse in June 2011. He was also assessed by two CPNs in November 2011. He was then supported by a social worker in the short-term team. Mr U had a care coordinator.

11.3.1 Comment

Arrangements to interview at least all trust staff who had contact with Mr T in 2011/2012 should have been made.

The trust investigation report provides a comprehensive record of the care of Mr T but provides little information about the care of Mr U. The report makes a number of statements about what it expects would have happened in respect of communications between different parts of the service in contact with Mr T. However, it found no evidence of these communications because of poor record keeping. The focus of the report's finding is on poor record keeping and two recommendations were made in respect of this. The two CPNs who saw Mr T in November told us of difficulty in record keeping because of time constraints.

The trust report includes significant gaps and trust senior managers have accepted that the report is of poor quality. It does not address a number of key issues, in particular:

- whether psychotherapy was the most appropriate response to the referral request;
- whether a more co-ordinated multi-agency approach should have been taken to the assessment of Mr T's needs given that he was known to the mental health trust, probation, drug and alcohol services and his children were on the child protection register;
- whether safeguarding issues were identified and acted upon in accordance with trust policy and national standards;
- whether the concerns of Mr T's partner and the social worker from local authority children and families service were appropriately responded to;
- whether the referral to the short-term team was appropriate;
- why was a request for an assessment by a psychiatrist not acted upon;
- whether the risk assessment carried out on 21 November 2011 was comprehensive and appropriate; and
- whether Mr T should have been discharged on 6 February 2012.

Our expert forensic psychiatrist said:

> "Whilst the Serious incident review action plan addresses most of the … issues it does not highlight the variance from the trust (risk) policy which took place and therefore the learning that needs to be gained as an organisation on this matter."

The report says little about Mr U. He was receiving care from the trust at the time of his death. The report did not look at whether Mr U should have been subject to MAPPA or at the objectives of his care plan and any risk management arrangements. The lack of recent notes on his case makes it difficult for us to comment on these matters.

The terms of reference for the internal investigation are only partially addressed.

The serious incidents requiring investigation policy in force at the time says an internal investigation oversight group will be formed to (among other things) review the quality of reports.

The clinical director, head of mental health services (the report's author), two social workers and the patient safety and compliance manager met at a review panel on 8 June 2012 when they accepted the report.

The locality director told us what would happen if the commissioning manager was not content with the robustness of the report before the meeting:

> "It would need to go potentially to have some additional work done and, depending on where the gaps were, I would want to ensure that the content covered all of the areas."

The report's author told us:

> "I finished the report and it then went to the clinical director, and I think to … the governance lead, who had a look at the report. Then there were I think a couple of conversations around clarifying some of the content."

11.3.2 Comment

> The trust accepted the report and its recommendations. It included several points where it could have challenged its quality and robustness but did not. We think this was the responsibility of the trust and not of the investigating officer. She was put in the difficult position of conducting an investigation without proper training and into a service she had only recently taken over. The report did not benefit from any real challenge during investigation and writing.
>
> The nature and purpose of the investigation were unclear: was it effectively an IMR to report to a wider multi-agency investigation? Or a stand-alone serious incident investigation? Whatever confusion existed about the status of the investigation, internal investigations must be undertaken as serious incident

investigations. The trust accepted that the investigation and report should not have been undertaken in the way they were.

11.3.3 Finding

F7 The trust serious incident investigation and report was inadequate as a means of reviewing the care of Mr T and Mr U. It was also inadequate as a means of learning for the trust.

11.4 Report recommendations and action plan

The internal report made two recommendations which were about record keeping. The trust told us it accepted that record keeping was generally poor. The trust said one of the reasons for this was a lack of literacy in the workforce. However, we saw no examples of poor literacy in the records. Some of the recording was poor but literacy did not appear to be the problem. The trust senior management team told us they had made improvements in patient record keeping and were improving community record keeping with an audit.

The trust managers supplied us with a report on a CPA audit which showed compliance of 79 per cent against a target of 95 per cent as at 26 July 2013. We did not understand how this related to record keeping.

11.4.1 Comment

The trust appears not to have a strategy for improving record keeping.

11.4.2 Recommendation

R8 The trust should develop and implement a strategy for improving record keeping.

11.5 Current investigation processes

The deputy director of governance told us the trust now undertakes investigations differently, with more challenge and scrutiny at each stage and inquiries are conducted only by trained investigators. The terms of reference are agreed at the outset and a clear time frame established. The appointed investigators are now not in a line management relationship with the service being investigated. Formal scrutiny takes place at the Patient Safety Review Group, which includes executive members of the trust board, with a summary report of investigation outcomes being submitted to the Quality Executive Group, which also includes trust board executives among its members.

However, the board does not receive reports of individual homicide inquiries and non-executive directors are not routinely involved with and do not see individual serious incident reports. The Quality Executive Group receives themed reports of serious untoward incidents.

We were told by senior managers that investigation reports are scrutinised and amended at a local level by the patient safety and compliance manager as part of a

locality serious incident requiring investigation (SIRI) panel. The investigating officer is part of the panel. They are then presented to the Patient Safety Review Group (chaired by the deputy director of governance).

Recommendations agreed at the Patient Safety Review Group and with commissioners should be implemented within an agreed time. Responsibility for the implementation of recommendations rests with the locality clinical director in association with the locality director. No further scrutiny of the implementation of the recommendations takes place and neither the quality executive nor the board have any way of routinely monitoring implementation.

11.5.1 Comment

We think the current system for conducting SI investigations contains weaknesses. The lack of involvement by non-executive directors and the fact that investigation reports are not taken to the board seriously hampers the board's ability to hold the executive to account and to learn lessons from the investigation. Part of the role of the non-executive director is to provide independent challenge, as the Mid Staffordshire Hospital public inquiry has shown.

We accept that a large number of incident reports do not need to be individually reviewed by the board, but the board and non-executive directors should always review reports on investigations of level 5 incidents, as required by the trust's 2013 policy on serious incidents.

Not requiring the investigating officer to present findings to the Patient Safety Review Group meeting seriously reduces the level of scrutiny that the report is subject to. In these circumstances, the investigating officer loses accountability and challenge for their investigation and cannot explain and face questions about their findings and recommendations.

We think the process for implementing and monitoring recommendations from investigations is not robust and that the board must have a means of monitoring progress on the implementation of recommendations.

11.5.2 Recommendation

R9 The trust should amend its policy for investigating serious incidents and reporting on them to ensure sufficient challenge and scrutiny are built into the process. The board, including non-executive directors, should receive a full report from all level 5 incidents as well as themed reports. The board should be able to assure itself about the progress of recommendations from all serious incidents.

12. Appendix A - Biographies

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations. Before joining Verita he served for eight years as a non-executive director of a mental health trust with board-level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting (UKCC). He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain. Tariq also served as a council member of the UKCC and deputy chair of two national nursing boards.

Andy Nash

Andy has extensive experience of working at a senior management level in local and central government, the NHS and in regulation (as a social services inspector) and service improvement (as a director in the National Institute for Mental Health in England). His background is in social work, social care and mental health and he has held several posts with dual accountability to the NHS and local or central government. He was seconded for several years to the Department of Health to work on the development and implementation of mental health and social care policy.

Andy is currently an independent consultant. Recent projects have included work with the Strategic Health Authority Mental Health Leads, Interim Head of Mental Health for a SHA, mentoring senior managers and conducting an independent mental health inquiry.

Dr Sian McIver

At the time the investigation was carried out Dr Sian McIver was consultant forensic psychiatrist for West London Mental Health NHS Trust and based at Broadmoor hospital.

13. Appendix B – Documents reviewed

- Mr T clinical and RiO records
- Mr U clinical RiO records
- Internal investigation report and updated action plan
- Community team structure chart
- *Being open policy.* 2008, 2012.
- *Care progamme approach policy.* 2011, 2012.
- CPA process audit. July & November 2012
- *Data subject access request policy.* 2009, 2011.
- *Information for patient's policy & procedures.* 2012.
- *Information governance policy*. March and August 2011
- *Information sharing protocol.* 2012.
- *Interagency working policy.* 2009, 2010, 2013.
- *Interagency Joint Working Protocol for the Management of Mental Health Thames Valley Area.* 2013.
- *Person identifiable data policy.* 2009, 2011.
- *Risk assessment: clinical policy*. 2010, 2011, 2012, 2013.
- *Risk assessment: corporate policy.* 2011, 2013.
- *Safeguarding adult's policy.* 2011, 2013.
- *Adverse events/serious untoward incidents policy.* 2011, 2013.
- *Guidelines for best practice in record keeping.* 2013.
- *Health records management policy.* 2013.
- *Clinical audit policy & procedures.* 2012.
- Referral criteria for Berkshire complex needs service and service inclusion and exclusion criteria.
- MAPPA Thames Valley protocol

14. Appendix C – List of interviews

- Deputy director of governance
- Mr U's care coordinator
- Psychotherapist
- CMHT social worker
- Locality head of mental health services
- West Berkshire locality head
- CPN, common point of entry team
- CPN, urgent care team
- Internal inquiry author
- Head of children and families services, West Berkshire Council
- Group meeting with trust senior managers

15. Appendix D - National definition of CPA

The national CPA guidance says that service users should get help under CPA if they have:

1. A severe mental illness (including personality disorder).

2. Problems with looking after themselves including:
   - self-harm, suicide attempts, harming other people (including breaking the law);
   - a history of becoming unwell and needing urgent help;
   - not wanting support or treatment;
   - vulnerability (for example, financial difficulties because of mental illness, physical or emotional abuse, being open to exploitation);
   - severe distress at the moment or you have felt a lot of severe distress in the past;
   - problems working with mental health services or have done in the past;
   - another non-physical condition alongside mental illness (for example, learning disability, drug or alcohol misuse);
   - services from a number of agencies, such as housing, physical care, criminal justice or voluntary agencies;
   - recently been detained under the Mental Health Act or are detained at the moment;
   - recently been put in touch with the crisis/home treatment team or are getting their help at the moment; and
   - a need for a lot of help from carer(s) or providing a lot of care to someone (children or an adult).

3. Disadvantage or difficulties due to:
   - parenting responsibilities;
   - physical health problems or disability;
   - unsettled accommodation or housing issues;
   - employment issues;
   - mental illness significantly affecting your day-to-day life; and
   - ethnicity (for example, immigration status, language difficulties, sexuality or gender issues).

16. Appendix E - CMHT organisational chart