HASCAS
Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment Provided to Mr X, Ms Y and Mr Z

by the Dorset HealthCare University NHS Foundation Trust

EXECUTIVE SUMMARY

Commissioned by NHS England

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Contents

1. Investigation Team Preface

1.1. The Independent Investigation into the care and treatment of Mr X (the victim of homicide), Ms Y and Mr Z (the perpetrators of the homicide) was commissioned by NHS England pursuant to *HSG (94)27.*[1] The Investigation was asked to examine a set of circumstances associated with the death of Mr X who was found dead on 27 July 2012. The decision was made to investigate the care and treatment received by each of the three individuals as all three were service users with the Dorset HealthCare University NHS Foundation Trust.

1.2. Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

1.3. Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and to those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has engaged fully with the root cause analysis ethos of this work.

2. Condolences to the Family and Friends of Mr X

2.1. The Independent Investigation Team would like to extend their condolences to the family and friends of Mr X. We met with Mr X's younger brother and are grateful to him for the time that he gave to us and the insights that he offered which supported the work of the Investigation.

1. Health Service Guidance (94) 27

3. Incident Description and Consequences

Background for Mr X (deceased)

3.1. Mr X was originally from Portugal and born on 29 October 1967. He was a registered sex offender who was placed on level 1 of the Multi Agency Public Protection Arrangements (MAPPA). At the time of his death he was known to the Bournemouth North Community Mental Health Team (CMHT). He had also been known previously to the local addictions team. Mr X had 24 convictions relating to 42 offences. Dorset police noted that of these offences:

- six were against the person;
- two were of a sexual nature;
- 19 related to theft;
- two related to public order;
- nine were against the police;
- two were drug related;
- two involved offensive weapons.

3.2. Mr X was single and at the time of his death was 44 years old. He had been diagnosed as having Schizophrenia and substance misuse problems.

Background for Ms Y (perpetrator of the homicide)

3.3. Ms Y was born on 29 December 1956. She was known to Bournemouth-based CMHT services for several years between 1998 and her eventual discharge in April 2012; she had a diagnosis of Emotionally Unstable Personality Disorder/Borderline Personality Disorder and it was recognised that she also had substance misuse problems. It would appear that Ms Y had been in trouble with the law on several occasions and it was recorded within her clinical files that she had a significant forensic history. Ms Y has three convictions for seven offences, mostly drug related (possession and supply of cannabis and heroin). She was first convicted in 1991. Ms Y has also been arrested and charged on several additional occasions these include:

- a charge of grievous bodily harm when aged 21 years (1977);
- having been in prison on remand in 1989 *"for a murder inquiry"*;
- stabbing two men whilst under the influence of Cocaine for which offence she received a Court Order and Drug Rehabilitation as an alternative to prison (1990s);
- stabbing her boyfriend in the thigh with a fork in 2009, for which she was arrested;
- seven charges for drug dealing, some with threats of violence;

3.4. Ms Y was discharged from mental health services in April 2012, three months prior to the killing of Mr X. She had a long-standing relationship with Mr Z who she had known for at least twelve years. This relationship was chaotic and the police had been involved in several domestic violence incidents in which she was alternatively both the victim and the perpetrator.

Background for Mr Z (perpetrator of the homicide)

3.5. Mr Z was born on 8 March 1972. He first came to the attention of Bournemouth-based mental health services in 1998 when he was referred by his GP for his alcohol problems. Mr Z had a diagnosis of Emotionally Unstable Personality Disorder - Borderline Type. Mr Z's contact with services ceased in 2009. He has several convictions for theft and public order offences. In total he has 10 convictions for 12 offences. These are broken down as; one offence against property, two theft offences, seven against police and Courts and two miscellaneous offences. He was first convicted in 1991.

Incident Description and Consequences

3.6. Mr X and Ms Y lived in the same block of flats. Witnesses to the murder trial stated that a feud had been running between them for years as a result of Mr X making a great deal of noise on an ongoing basis. Neighbours reported to the police that arguments had been taking place *"for months"* prior to the homicide.

3.7. On the night of 27 July 2012 Ms Y had been drinking heavily. When she heard noise coming from Mr X's flat she became angry. Ms Y ran to Mr X's flat holding a scissor blade; Mr Z went with her. After Mr X opened his front door Ms Y and Mr Z pushed him backwards through his hallway. Mr Justice Males said: *"… [Mr Z] and … [Ms Y] pushed … [Mr X] backwards through his hallway and into his bedroom and got him down on the bed… [Mr Z] sat astride him, punching his face repeatedly and pinning his arms so that he couldn't defend himself while … [Ms Y] stabbed him in what must have been a frenzied attack. She inflicted a total of 25 injuries with a scissor blade".*

3.8. As a consequence Mr X died of his wounds. Ms Y and Mr Z were convicted of murder and sentenced to life imprisonment to serve a minimum of 16 and 14 years respectively.

4. Terms of Reference

1. Purpose of the Investigation

4.1. To identify whether there were any aspects of the care Ms Y, Mr Z and Mr X received, which could have been predicted and/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 from occurring.

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

1.1. Main Objectives

1. To establish if the risk assessment and risk management of Ms Y, Mr Z and Mr X was sufficient in relation to their needs including the risk of self-harm or harm to others (wider safeguarding issues).
2. To evaluate the mental health care and treatment from primary and secondary care that Ms Y, Mr Z and Mr X received, including the adequacy of the risk assessments and risk management.
3. To identify key issues, lessons learnt, recommendations and actions by Dorset Healthcare University NHS Foundation Trust and all those directly involved in providing the care plan.
4. To independently assess and provide assurance on the progress made on the delivery of action plans following the submission of the Trust's Individual Management Reviews.
5. To identify lessons and recommendations with wider implications so that they are disseminated to other services and other agencies such as housing, police and local authorities.
6. Identify care or service delivery issues, along with the factors that might have contributed to the incident including engagement with services and staff.

2. Terms of Reference

1. Review the assessment, treatment and care that Ms Y, Mr Z and Mr X received from Dorset HealthCare University NHS Foundation Trust up to the time of the incident.
2. Review the care planning and risk assessment, policy and procedures and compliance with national standards.
3. Review the communication between agencies, services, friends and family including the transfer of relevant information to inform risk assessment.
4. Review the documentation and recording of key information.
5. Review the communication, case management and care delivery.
6. Review the Trust's Individual Management Reviews (which acted as the Trust's internal investigation) and to assess the adequacy of their findings, recommendations and action plan and identify:
   - if these reviews satisfied the terms of reference;
   - if all key issues and lessons have been identified and shared;
   - 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.
7. Review any communication and involvement with families of the victim and perpetrator before and after the incident.
8. Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the internal investigation process.
9. Review the relevant agencies involvement from Ms Y, Mr Z, and Mr X's first contact with services to the time of the offence.
10. Consider if this incident was predictable or preventable.

3. Level of Investigation

5.3. **Type B:** a focused investigation by a team examining a single case.

4. Timescale

5.4. The investigation process should be completed within six months of receipt of all clinical and social care records up to the time of the incident.

5. Initial Steps and Stages

NHS England will:

- Arrange an initiation meeting between the Trust, commissioners and other agencies willing to participate in this investigation (provisional dates in June/July 2014).
- Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved.
- Seek full disclosure of the perpetrator's medical records to the investigation team and with a view that the report will be published in the public interest.

6. Outputs

1. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care.
2. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome.
3. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed).
4. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.
5. At the end of the investigation, to meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation.
6. A concise and easy to follow presentation for families.
7. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required.
8. We expect the investigators to include a lay/family member/service user on the panel to play a meaningful role and bring an independent voice and challenge to the investigation and its processes.
9. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assess and assure NHS England and the commissioners if the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public.

10. The independent investigator may consider other issues that warrant further investigation and comment.

5. The Independent Investigation Team

Selection of the Investigation Team

5.1. The Investigation Team was comprised of individuals who worked independently of the Dorset HealthCare University NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Chair

Dr Androulla Johnstone	Health and Social Care Advisory Service Chief Executive - Chair, nurse member and report author.

Investigation Team Members

Dr Liz Gethins	Health and Social Care Advisory Service associate and consultant psychiatrist member of the team.
Mr Frank Mullane	Chair AAFDA and Victim support advisor to the team and lay member.
Mrs Tina Coldham	Health and Social Care Advisory Service associate and service user member of the team.

Support to the Investigation Team

Mr Greg Britton	Health and Social Care Advisory Service Investigation Manager

Independent Advice to the Investigation Team

Kennedys Solicitors

6. Identification of the Thematic Issues

Root Cause Analysis

6.1. In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb;

- immediate cause = wrong limb operated upon (ask why?);
- wrong limb marked (ask why?);
- notes had an error in them (ask why?);
- clinical notes were temporary and incomplete (ask why?);
- original notes had been mislaid (ask why?);
- (because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

6.2. Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Court found Ms Y and Mr Z guilty of murder and they were sentenced to life imprisonment. Their history as service users with the Dorset HealthCare University NHS Foundation Trust was not seen as mitigation.

RCA Third Stage

6.3. This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. Areas of practice that fell short of both national and local policy expectation.
2. Causal, contributory and service issue factors.

6.4. The terms ‘causal factor’, ‘contributory factor’ and ‘service issue’ are used in this section of the report. They are explained below.

6.5. **Causal Factors:** in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term ‘causal factor’ is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide. No direct causal factors were found by the Independent Investigation Team in relation to the care and treatment provided to all three services and the death of Mr X.

6.6. **Contributory Factors:** the term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown of a service user’s mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party.

6.7. **Service Issue:** the term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the death of Mr X need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

6.8. The findings in this chapter analyse the care and treatment given to Mr X, Mr Z, and Ms Y. The reader is referred to the narrative chronology for supporting information.

Thematic Issues

6.9. The Independent Investigation Team identified 13 thematic issues that arose directly from analysing the care and treatment that Mr X, Ms Y and Mr Z received from the Dorset HealthCare University NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis.** Ms Y and Mr Z received appropriate and timely diagnostic assessment. Mr X however had a five-year delay in the provision of a formal diagnosis. This meant that on occasions the care and treatment provided to him was not optimal and his Schizophrenia went only partially treated for a number of years.

   - ***Contributory Factor 1. Mr X did not receive the correct diagnosis for many years. This had a direct impact on the care and treatment model offered to him as he was not understood appropriately in the context of his mental illness and poly-substance misuse.***

2. **Medication and Treatment.** The care and treatment provided to all three services users was delivered by both primary and secondary care services with kindness and compassion. It is also evident that both Ms Y and Mr Z received, on the whole, an evidence-based approach to their care and treatment needs.

   The Dialectical Behaviour Therapy (DBT) model provided by the CMHT provided an innovative approach to the care and treatment of chaotic service users with Personality Disorder. However this model, at times, served to displace the approach taken with other service users with severe and enduring mental illness. Mr X was provided with robust input for his Heroin addiction by the Bournemouth Addiction Team, but his care and treatment from the CMHT was hampered by poor diagnostic processes. This meant that his Schizophrenia went partially treated, up until late 2011 and the care and treatment package he was offered did not address his needs in a holistic manner.

   - ***Contributory Factor 2. Mr X did not receive a full and appropriate care and treatment package in keeping with his complex presentation and ongoing psychotic symptoms.***

3. **Use of the Mental Health Act (1983 and 2007).** There were no issues identified regarding the use of the Mental Health Act in relation to Ms Y or Mr Z. Neither met the criteria for detention either before the homicide or after - this was also a finding of the Court.

   It would appear that on occasions Mr X did meet the criteria for detention under the Act. However Mr X was allowed to continue in a self-directed manner in the community and his risks, either to himself or to others, were not primarily viewed through the lens of his Schizophrenia. Whilst eventual decisions not to assess Mr X under the Act had no bearing on his death, opportunities were missed that

would have afforded an in-depth period of assessment of his mental state on an inpatient unit.

4. **Care Programme Approach (CPA).** There were generic, systemic and service user specific issues found in relation to CPA and Care Coordination. There was poor adherence to, and understanding of, CPA and Care Coordination within the North Bournemouth CMHT. This was compounded by resourcing issues and a disproportionate focus upon the DBT model. The Trust acknowledges that there remains a culture within many of its community teams of viewing CPA as a bureaucratic process only which takes them away from patient care. This has historically led to non-compliance with Trust CPA policy.

   The North Bournemouth CMHT appears to have understood the notion of Enhanced or full CPA to have meant additional levels of monitoring and support. This is an entirely appropriate core function of CPA. However CPA within the CMHT did not always extend to meet another of its core functions; that of interagency/service and multidisciplinary assessment of need, ongoing communication and holistic care planning.

   Limited Care planning did take place but did not extend, in the case of Mr X, to either a medium or long-term plan to support his ongoing social functioning, recovery and wellbeing needs.

   - ***Contributory Factor 3. The CMHT did not implement CPA in keeping with Trust policy guidance. This was exacerbated by the DBT service model as operated by the CMHT which required extensive input and reduced the capacity of the team. Whilst this did not have a direct causal link to Mr X's death it created the circumstances where his mental health was neither managed nor monitored appropriately and left him over time in a position of increased vulnerability especially when actively psychotic.***

   - ***Service Issue 1. CPA processes were weak and did not adhere to policy expectation.***

5. **Risk Assessment.** There were generic, systemic and service user specific issues found in relation to risk assessment.

   Systemic issues included a lack of a risk assessment culture within the North Bournemouth CMHT. There was a prevailing notion that risks could not always be managed and were dynamic in nature; this led to the view that risk assessment processes had a limited level of use and so were not focused upon. Risk assessment policies went unread and clinical staff within the CMHT had not received risk assessment training for many years. Another systemic issue was that of risk screens only being completed which meant that events of a serious nature and/or significant changes in a service user's mental state did not lead to a full risk assessment being undertaken.

   Generic issues for all three service users included:

- the lack of Police National Computer (PNC) information being sought (save on one occasion in November 2004 for Ms Y);
- a lack of forensic psychiatry referral – even when indicated;
- a lack of diagnostic and risk formulation and risk management crisis/contingency planning.

Service user specific issues are manifold. In summary: they included Multiagency Public Protection Arrangements (MAPPA)); Multi-Agency Risk Assessment Conference (MARAC) processes; and safeguarding.

- ***Contributory Factor 4. Mr X's risks and resulting antisocial behaviour were not understood fully in the context of his Schizophrenia. This meant that no strategies could be developed to maintain his safety and the safety of those around him.***

- ***Service Issue 2. Risk assessment and management processes were weak and did not adhere to policy expectation.***

- ***Service Issue 3. Interagency working was weak and important opportunities were missed in relation to MAPPA and information sharing.***

6. **Referral and Discharge Planning.** Prison referral and discharge processes were weak and in November 2006 led to Mr X being lost to service for several weeks following his release from detention.

   General referral processes were unremarkable. However discharge procedures often did not include a risk assessment and a comprehensive transfer of risk information back to primary care.

   - ***Service Issue 4. Prison referral and discharge processes were not robust in the case of Mr X. The Independent Investigation Team was told that these processes are still problematic.***

7. **Safeguarding.** The Bournemouth, Dorset and Poole Multi-Agency Adult Safeguarding Policy is a clear, evidence-based and useful document. It could be argued that Mr X, Ms Y and Mr Z on occasions all met the criteria for an 'Adult at Risk of Abuse' as defined within the policy. Whilst the use of the safeguarding process was not as clearly indicated as MAPPA, MARAC, risk assessment and CPA, it would have provided a useful additional framework to have assessed vulnerability and risk against.

   However whilst the adult safeguarding process could have been selected as an appropriate vehicle by which to manage the vulnerability and risk of Mr X, Ms Y and Mr Z the decision not to do so did not make a contribution to the death of Mr X.

8. **Interagency Working.** Interagency working was poor with organisations operating in silos. This was exacerbated by weak Care Coordination processes.

- ***Contributory Factor 5. Interagency working was poor with organisations working in silos. This made a contribution to the poor overall management of Mr X and Ms Y.***

- ***Service Issue 5. Poor ongoing communication and working processes between Addictions Services and other agencies may limit the learning from this Investigation and others in the future.***

9. **Service User Involvement in Care Planning and Treatment.** A key finding of the Independent Investigation Team is the kindness and compassion that was evident in the delivery of care and treatment to all three service users across all Health provision. Each of the three service users were consulted in full about the care and treatment that was offered to them and it is evident that, where possible, informed consent was sought and the subsequent approach agreed with them. This was good practice. However services need to consider the following:

    - it is sometimes necessary to intervene, even if it is against a service user's wishes;
    - cultural awareness can be a complex process especially when conducting in-depth clinical assessment;
    - person-centred care and treatment plans are always required for service users with severe and enduring mental illness and should encompass social functioning, recovery and wellbeing.

10. **Carer and Family Concerns.** The needs, risks, and roles of families and carers were neither understood nor addressed by Trust services over time. There were missed opportunities to:

    - gather corroborative information;
    - strengthen care plans for the service users (especially in the case of Mr X in relation to his brother's input);
    - ensure the safegaurding and general safety of relatives and carers;
    - undertake carer assessments;
    - explore family dynamics and provide education and support.

    - ***Service Issue 6. Families and carers were 'invisible' to secondary care mental health services. Potential risks were neither identified nor managed and carer assessments when indicated were not provided.***

11. **Documentation and Professional Communication.** Professional communication across primary and secondary care services was poor. There are three main reasons for this, each one exacerbating the others.

    - Clinical record keeping was, and is, weak within the North Bournemouth CMHT. Currently this appears to be due, in part, to the RiO system which – staff report - is cumbersome and difficult to use. This means that the clinical record does not accurately represent the work that is being undertaken.

- The different electronic clinical recording systems currently in use across services do not speak to each other. This means that information is difficult to access in a timely manner.
- There is a prevailing culture of informal professional communication which does not foster either a multidisciplinary or interagency approach. This culture is fostered by the poor use of CPA and Care Coordination which should act as a communication and liaison link across all disciplines, services and agencies.

- ***Service Issue 7. Documentation and professional communication processes were, and are, weak. This prevents the sharing of information in a timely manner and also acts as a barrier to joint working.***

12. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** There are long-standing issues in relation to policy compliance within the Trust and these are still ongoing at the present time. The issues indicate problems with both process and culture and appear to be deeply ingrained. The failure to adhere to policy and procedure has meant that the services under investigation have not adhered to either local or national good practice guidance. This failure compromised the quality and effectiveness of the care and treatment Mr X, Ms Y and Mr Z received.

- ***Contributory Factor 6. Poor understanding of, and compliance to, Trust policy and procedure led to a situation where the care and treatment of Mr X was suboptimal and where the risks presented by Mr X and Ms Y were poorly identified and therefore poorly managed.***

13. **Clinical Governance and Performance**. At the time Mr X, Ms Y and Mr Z were service users with the Trust it is evident that significant policies were not adhered to and this compromised the effectiveness and quality of the care and treatment that they received. No single practitioner was responsible for this because systems were inadequate and failed to ensure staff had a clear understanding of what was expected of them. This was compounded by poor staffing levels, heavy caseloads and a monitoring and regulation process that was too weak to detect failings.

- ***Contributory Factor 7. There was failure of Trust governance systems to ensure an evidence-based approach was taken and maintained in keeping with both local and national good practice expectation.***

7. Conclusions Regarding the Care and Treatment Mr X, Ms Y and Mr Z Received

Overview

7.1. The Independent Investigation Team concludes that the care and treatment Mr X, Ms Y and Mr Z received was delivered with kindness and compassion by all staff

from primary and secondary care teams. We do not seek to single out the practice of any individual as either 'failing' or being responsible for any of the care and treatment shortcomings that this Investigation has identified.

7.2. Through conducting a Root Cause Analysis process it has been possible to understand the identified shortcomings are systemic in nature and we have endeavoured to explore this within the report in sufficient detail so that the necessary changes can be made in an effective manner.

7.3. HASCAS Health and Social Care Advisory Service also conducted an earlier Independent Investigation into the care and treatment of another service user at the Trust. This report was published in 2013. Many of the issues and service shortcomings identified in this previous Investigation are similar to those identified in this one. This serves to strengthen our conclusion that the shortcomings were systemic in nature. Key comparable findings are:

- poor levels of compliance with policy and procedure;
- weak governance processes that were unable to detect policy non-compliance;
- poor levels of understanding of CPA and Care Coordination processes;
- poor levels of understating of clinical risk assessment and management processes;
- a Duty on Call system that takes Care Coordinators away form their caseloads;
- a lack of carer assessment and support;
- poor standards of documentation and professional communication which prevented joined-up care from taking place;
- problems with interagency linkages regarding potential safegaurding issues.

7.4. The death of Mr X took place nearly three years ago. However many of the managers and clinical witnesses we spoke to described aspects of practice that are still current which are directly comparable to the poor practice of the past. This would indicate that despite the work the Trust is engaged in at the present time there is still a great deal of work to do in order to ensure a quality and safe patient service is guaranteed.

Predictability and Preventability

Predictability

7.5. Based upon what *was* known and what s*hould* have been known about all three service users it is easy to ascertain that Mr X, Ms Y and Mr Z were complex and presented with high levels of risk to both themselves and to others. It was entirely predicable, based upon historic fact that an untoward incident of some kind was likely to occur in the future to one or all three of the service users. However the Independent Investigation concluded that the death of Mr X could not have been predicted by services under the circumstances in which it occurred.

Preventability

7.6. Based upon what *was* known and what s*hould* have been known about all three service users the Independent Investigation Team concludes that the death of Mr X could not have been prevented. At the time of his death all three service users appeared to have been stable and there were no concerns in relation to their mental health. In order for an incident of this kind to be preventable three criteria have to be met. They are:

- knowledge;
- opportunity;
- legal means to intervene.

7.7. **Knowledge:** During the period immediately before Mr X's death there was no indication to suggest that the relationship between Mr X, Ms Y and Mr Z had deteriorated to the point where any act of violence would take place. Services therefore did not have the knowledge and there was no warning which might have prompted an intervention.

7.8. **Opportunity:** None of the services or agencies involved had the opportunity to intervene as there was no knowledge that this would be necessary.

7.9. **Legal Means:** As far as can be ascertained, at the time of Mr X's death none of the service users involved met the criteria for either assessment or detention under the Mental Health Act. Mr Justice Males convicted Ms Y and Mr Z of murder and sentenced them to life imprisonment to serve a minimum of 16 and 14 years respectively. No mitigation was found in relation to their mental health.

Summary

7.10. The Independent Investigation Team concludes that Mr X met his death through no act or omission on the part of either primary or secondary care NHS services. Six contributory factors have been identified in relation to shortcomings in the care and treatment provided, most of which had a direct impact on the failure to promote Mr X's quality of life, recovery and wellbeing. Seven service issues have been identified, which whilst having no specific bearing on the care and treatment of Mr X, Ms Y and Mr Z, demonstrate the need for actions to be taken in order to ensure effective and safe patient care and treatment in the future.

8. Notable Practice

8.1. The death of Mr X took place in July 2012 – over three years ago. Since this time Dorset HealthCare University NHS Foundation Trust has undertaken many service improvements. There were several areas of notable practice highlighted during the course of the Investigation. These areas of notable practice are significant and of relevance to other mental health providers across the country. HASCAS Health and Social Care Advisory Service has significant experience of working with mental health Trusts across the country and is of the view that work currently being undertaken in Dorset is of an exceptionally high standard and truly innovative in approach. Examples are as follows:

Pre Homicide

1. **Care and Compassion:** Over time the treating teams for each of the three service users provided compassionate care and treatment. Services worked hard and engaged with Mr X, Ms Y and Mr Z in a respectful, professional and non-judgemental manner at all times. It is apparent that for at least a decade Personality Disorder has not been regarded as a diagnosis of exclusion and a robust care and treatment pathway has been developed and implemented.

Post Homicide

2. **Working with the Police and MAPPA Processes:** The Trust has an excellent example of notable practice regarding the work that it has conducted in conjunction with the Dorset Police and associated Criminal and Youth Justice Partners (please see appendices two and three). Dorset mental health services have also developed a street triage pilot which has recently been extended and works with the police to get people into health services rather than custody. Dorset police and mental health services are now working together to ensure mental health service users with emergency acute episodes of care are managed appropriately and not confined in police cells. To this end a *"Staying Safe"* workbook has been developed and training provided to the police in relation to mental health issues and management. There is a police and mental health forum working at grass roots level across agencies to address needs of vulnerable individuals - such as Mr X - whose situation would now be highly visible to services and managed differently.

3. **CPA:** The Trust currently conducts regular audits and operates a robust dashboard system to monitor CPA compliance across the organisation. Of note is the development of a service user CPA guidance leaflet and a staff CPA Review Guidance Pack. Both documents set out clearly the key roles and responsibilities of both service users and Trust and provides a practical set of instructions about to get the most out of the CPA process. These documents are of an excellent quality, easy to work through and full of evidence-based best practice guidance.

4. **Carer Strategy:** A three-year Carer Strategy has been developed. The strategy acknowledges that carers, service users and mental health services need to work in partnership in order to promote recovery. The strategy states that *"We believe that carers should be able to seek the support they need at the time that they need it and that they should be recognised as expert partners in care"* and sets out how this should be achieved. This strategy has been shaped by the updated Triangle of Care document (Worthington et al, 2013). The Triangle of Care identifies 6 core elements to effectively support carers.

    - Carers and the essential role they play is identified at first contact or as soon as possible thereafter.
    - Staff are 'carer aware' and trained in carer engagement strategies.
    - Policy and practice protocols regarding confidentiality and sharing information are in place.
    - Defined post(s) responsible for carers are in place.
    - A carer introduction to the service and staff is available, with a relevant range of information across the acute care pathway.
    - A range of carer support services is available.

    The Triangle of Care also calls for regular assessment and auditing of providers to ensure these six elements are in place.

    HASCAS is of the view that this strategy could form a sound basis for other organisations who are currently reviewing carer support and assessment practice.

5. **Adult Mental Health Care Pathway:** The Trust is currently in the process of developing an Adult Care Pathway. The pathway is being developed with the Clinical Commissioning Group and via a series of public consultation forum events to ascertain early feedback. The consultation process will be completed by April 2016. This work in notable, not only in that it seeks to provide a robust pathway through referral, transfer and discharge processes, but due to its inclusivity and consultation with the public and partner organisations.

6. **Mental Health Foundation Learning Pathway:** The draft pathway document states that *"In recent years, the need for a foundation learning pathway has become increasingly apparent in order to ensure that mental health staff new to the trust are provided with a standardised platform of learning and development in the first year of being in post. This pathway has, therefore, been developed to provide a range of level one courses which are considered fundamental to effective practice in mental health".* The pathway will become fully operational by the time of the publication of this Investigation report and will apply to all registered and non-registered clinical staff.

9. Lessons for Learning

9.1. There are three key significant lessons for learning. These lessons are pertinent to the Trust and are also transferable to other mental health providers across the country.

1. **CPA, Risk Assessment and the taking of a Psychiatric History:** The development of a comprehensive psychiatric history is of the utmost importance. Over the years - due to such things as *News Ways of Working*, the advent of the electronic clinical record and the fragmentation of mental health services - many service users no longer have a detailed history complied and/or updated. In the case of Mr X and Ms Y this served to present a distorted view of the risks that they presented both to themselves and to others. It is probable that had services been able to access a full history of these individuals a different approach would have been taken regarding care and treatment decisions.

   CPA and clinical risk assessment constitutes basic building blocks of care and treatment. These processes should be a dynamic and should take into account a service user's history and current presentation. The assessment and management of risk should always be managed in accordance with Trust policy no matter how challenging services may be to deliver.

   Basic building blocks of care should consist of:
   - a sound knowledge of the patient;
   - a psychiatric history to be taken;
   - an assessment of mental state;
   - an assessment of need;
   - an assessment of risk;
   - a diagnostic and risk formulation;
   - clear and well communicated care plans;
   - clear and well communicated risk management plans;

- clear and well communicated crisis and contingency plans.

Omissions in the provision of these basic building blocks cannot be countenanced as they form the core processes of evidence-based mental health care provision. Every health and social care professional has a duty of care to ensure that they are achieved. Every statutory service has a duty of care to ensure that they are carried out and that the resource available is adequate to do so.

2. **Interagency Working and Professional Communication:** HSG (94) 27 independent homicide investigations of this kind have consistently found causal factors in relation to homicides perpetrated by mental health service users and failures in levels of professional and inter agency communication. It is common for members of a treating team to know a service user well. It is also common for documentation to not always record all of the pertinent details known about any one individual. When service users are handed over from one treating team to another it is often the case that only partial information is imparted. In the case of Mr X it is evident that information was not always shared between treating teams and agencies, and whilst this did not make a direct causal contribution to his death, it represents a significant omission that had a negative effect on his quality of life and recovery.

3. **Internal Investigation Process:** The internal investigation process was aligned to that of the Safeguarding Adult Review and this was at the direct instigation of the Strategic Health Authority (now NHS England). In principle the commissioning of joint investigation processes is a good idea. It encourages joint working and joint lessons for learning opportunities across the health and social care continuum. However on occasions joint commissioning can yield investigations that are not as insightful as they need to be due to the adoption of frameworks that may not be a 'best fit'. In this case the Safeguarding Adult Review process and report template did not lend itself to the full examination and understanding of the underlying mental health management issues. This has led to a delay in services receiving a robust set of findings, conclusions and recommendations. In future investigations commissioning should be based upon the primacy of the issues - this should then lead to the assignment of the most appropriate investigation lead body or agency.

10. Recommendations

10.1. The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

10.2. The Independent Investigation Team worked with the Dorset HealthCare University NHS Foundation Trust and the NHS Dorset Clinical Commissioning group to formulate the recommendations arising from this investigation process. This has served the purpose of ensuring that current progress, development and good practice have also been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure

that they can improve further services and consolidate the learning from this inquiry process.

10.3. Each recommendation is set out below in accordance with the relevant progress that the Trust has already made since the time of the incident. The reader should note that most of the identified contributory factors and service issues will be addressed as part of the Trust's new Adult Care Pathway. However the Adult Care Pathway is still under development and the recommendations below - whilst acknowledging the good work already in train - sets out areas that should be incorporated into this work.

Recommendation One: Diagnosis, Medication and Treatment

Investigation Findings

- ***Contributory Factor 1. Mr X did not receive the correct diagnosis for many years. This had a direct impact on the care and treatment model offered to him as he was not understood appropriately in the context of his mental illness and poly-substance misuse.***

- ***Contributory Factor 2. Mr X did not receive a full and appropriate care and treatment package in keeping with his complex presentation and ongoing psychotic symptoms.***

Progress Made to-date

10.4. Work is currently ongoing with the construction of an Adult Care Pathway. However the Independent Investigation findings in relation to diagnosis, medication and treatment need to be made explicit within its development.

Recommendation

- ***The new Adult Care Pathway should make explicit the need for, and benefits of, a clear diagnosis/differential diagnosis for service users. The diagnosis, combined with service user presentation, should inform* any *ensuing care and treatment package which should comply with current NICE best practice guidance.***

Recommendation Two: The Care Programme Approach (CPA)

Investigation Findings

- ***Contributory Factor 3. The CMHT did not implement CPA in keeping with Trust policy guidance. This was exacerbated by the DBT service model as operated by the CMHT which required extensive input and reduced the capacity of the team. Whilst this did not have a direct causal link to Mr X's death it created the circumstances where his mental health was neither managed nor monitored appropriately and left him over time in a position of increased vulnerability especially when actively psychotic.***

- ***Contributory Factor 6. Poor understanding of, and compliance to, Trust policy and procedure led to a situation where the care and treatment of Mr X was suboptimal and where the risks presented by Mr X and Ms Y were poorly identified and therefore poorly managed.***

- ***Service Issue 1. CPA processes were weak and did not adhere to policy expectation.***

Progress Made to-date

10.5. The Trust has made significant progress in this area since the time of Mr X's death. Services have now changed in relation to the DBT approach and work has been ongoing to ensure full compliance with Trust CPA expectations. It has been a significant finding of the Independent Investigation that historic poor CPA practice has been exacerbated by a culture of poor policy compliance.

10.6. The Trust now has in place a comprehensive process of audit which monitors CPA and risk assessment compliance. Compliance can be tracked to each individual clinical team and dashboard findings are made available on a monthly basis. The data from current audits suggest that the Trust is achieving a 95 - 100 per cent success rate.

10.7. The Trust is not only monitoring compliance in relation to the CPA process - it is also actively managing quality. As has been set out in the notable practice section above - a detailed CPA guidance toolkit is available to all staff which is supported by training update programmes. This approach sets out the Trust's expectation clearly together with practical advice as to how to achieve CPA policy requirements and best practice guidance.

10.8. HASCAS has been able to access significant evidence regarding CPA service improvement and following discussion with NHS Dorset Commissioning Group concludes that significance progress has been made.

Recommendation

- ***The Trust should continue to undertake its audit programme and should in addition work with NHS Dorset Clinical Commissioning Group to increase the CPA compliance statistics still further. This to be examined in the light of the Trust's CPA guidance toolkit and revised training programme – the effectiveness of which should be subject to evaluation.***

Recommendations Three (a), (b) and (c): Clinical Risk Assessment

Investigation Findings

- ***Contributory Factor 4. Mr X's risks and resulting antisocial behaviour were not understood fully in the context of his Schizophrenia. This meant that no strategies could be developed to maintain his safety and the safety of those around him.***

- ***Service Issue 2. Risk assessment and management processes were weak and did not adhere to policy expectation.***

- ***Service Issue 3. Interagency working was weak and important opportunities were missed in relation to MAPPA and information sharing.***

- ***Service Issue 4. Prison referral and discharge processes were not robust in the case of Mr X. The Independent Investigation Team was told that these processes are still problematic.***

Progress Made to-date

10.9. Clinical risk assessment is now subject to regular compliance audits in the same manner as CPA. Currently the Trust has a 95 per cent compliance rate; the figures for which are endorsed by NHS Dorset Clinical Commissioning Group.

10.10. There is a new training pathway for mental health and MARAC champions in each CMHT; there is also MAPPA training in place. There is ongoing work taking place between the Trust, the police and probation services to ensure that offenders who fall 'sub MAPPA' are not lost to the attention of service. Had Mr X and Ms Y been open to service today their cases would have been managed differently in that information would have been gathered, risk alerted and a multi-agency process identified to manage them. However despite the progress made there remain information sharing difficulties as inter agency protocols are not yet aligned.

Recommendations

- ***3 (a) The Trust should continue to undertake its audit programme and should in addition work with NHS Dorset Clinical Commissioning Group to increase clinical risk assessment and management compliance statistics still further.***

- ***3 (b) The Trust and its partners from the police, MAPPA and probation services should consider the findings and conclusions of this Independent Investigation and route Mr X and Ms Y as case studies through current processes to ensure that service users with a similar profile would not be 'lost' to services today and that their management would be proportionate and robust. Information sharing protocols should be examined as part of this process to assess if they are fit for purpose.***

- ***3 (c) The new Adult Care Pathway should make explicit prison referral, transfer and discharge processes to ensure that service users with severe and enduring mental illness are managed in a seamless way between different agencies.***

Recommendation Four: Interagency Working

Investigation Findings

- ***Contributory Factor 5. Interagency working was poor with organisations working in silos. This made a contribution to the poor overall management of Mr X and Ms Y.***

- ***Service Issue 5. Poor ongoing communication and working processes between Addictions Services and other agencies may limit the learning from this Investigation and others in the future.***

Progress Made to-date

10.11. There is an acknowledgement that the new Adult Care Pathway will address to a large extent interagency and inter-service operational issues. However it is apparent that detailed work will be required in order to reconcile the manner in which mental health services, commissioners and the DAAT work with independent and third sector providers. This will be essential in order to guarantee a seamless care pathway for service users and to also ensure that in future lessons for learning can be determined when things go wrong.

Recommendation

- ***NHS Dorset Clinical Commissioning Group, the DAAT and the Dorset HealthCare NHS Foundation Trust should work with partner organisations to determine how best a multiagency approach can be taken to the Adult Care Pathway in order for it to be developed in the best interests of service users who access services and also in the best interests of public safety.***

Recommendation Five: Documentation and Professional Communication

Investigation Findings

- ***Service Issue 7. Documentation and professional communication processes were, and are, weak. This prevents the sharing of information in a timely manner and also acts as a barrier to joint working.***

Progress Made to-date

10.12. The Trust has recently moved to an upgraded version of RIO which should ensure better compatibility with the needs of clinical staff inputting onto the system. Net books are in the process of being issued to staff to ensure maintaining an interface is easier. However it is acknowledged that in parts of rural Dorset connectivity is set to remain an issue for some time. There remain several different electronic clinical record systems in place; VISION (local services aligned to the GP system) and HALO (DAAT database). This means that professional communication processes must ‘work harder’ if important patient information is to be shared in a consistent and timely manner.

Recommendation

- ***Information sharing protocols need to be built into the new Adult Care Pathway. This will be a complex task but will be essential in order to underpin new ways of working in the best interests of service users.***

Recommendation Six: Clinical Governance and the New Adult Care Pathway

Investigation Findings

- ***Contributory Factor 6. There was failure of Trust governance systems to ensure an evidence-based approach was taken and maintained in keeping with both local and national good practice expectation.***

Progress Made to-date

10.13. The Trust has completely reorganised its governance systems. This is detailed in section 12.13 above – HASCAS has confidence in the improvements made and conclude that these improvements will have a positive impact upon the areas of poor practice identified by this Investigation. At the time of writing this report the Trust was subject to Monitor and CQC inspections the outcome of which will not be known in time for inclusion into this Investigation.

Recommendation

- ***The Trust should act upon any recommendations set by Monitor and the CQC following the publication of their findings. HASCAS has no recommendations to make in connection with this Investigation.***

Recommendation Seven: Internal Investigation Process

Investigation Findings

10.14. The Independent Investigation found the internal investigation processes deployed were not detailed or robust enough to identify lessons for learning in a timely manner. This was in part due to the decision made by the strategic Health Authority (now NHS England) for the process to be aligned with that of the Safegaurding Adult Review.

Recommendation

- ***In future investigation commissioning should be based upon the primacy of the issues - this should then lead to the assignment of the most appropriate investigation lead body or agency.***