

# Independent Review of the care and management of Mr F

NHS England reference: 2019-7600

## Final report

30 August 2022



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## Acknowledgements

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

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

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## Executive summary

### Purpose of the investigation

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

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

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

### Terms of reference

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

- Critical analysis of the internal investigation's key lines of enquiry and whether these were appropriate, considered and explored, and highlighting any areas requiring further investigation.
- The review and assessment of compliance with local policies and national guidance, including the application of the Duty of Candour and statutory obligations including safeguarding.
- Thorough review of the clinical records; assess the care and treatment received by Mr F including review of the adequacy of risk assessments, risk management, and care planning including carers' assessment.
- Explore whether Mr F's family had alerted professionals to any mental health concerns and, if so, how this was acted upon.
- Review the appropriateness of the treatment of the service user in light of identified health and social care needs, identifying both areas of good practice and areas of concern.
- Identify any gaps or omissions in care not addressed within the investigation commissioned by South West Yorkshire Partnership NHS Foundation Trust.

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

- Assessing the reasonableness of the original internal investigation in terms of method and methodology.
- Assessing and reporting on the progress made against the implementation and effectiveness of the recommendations from the internal investigation.

### **Main findings**

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

These included:

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

### **Conclusion**

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

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

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

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

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

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

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

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

### **Recommendations**

The Trust can show that it has acted on all the action points set down in its action plan, constructed following its own internal investigation. The Trust's new approach to risk assessment, FIRM, is intended to address all the risk management practice and documentation concerns highlighted by its own investigation, this independent investigation, and via other investigations (internal and independent).

The recommendations below seek to address what CUK considers to be outstanding issues, and/or the need for auditable assurance that the actions already taken have delivered the improvements they were designed to achieve.

#### **Recommendation 1:**

##### **What is required:**

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

#### **Recommendation 2:**

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

- Focus groups of professionals, service users and families
- Peer review of record keeping, assessing content and quality of what is written
- Individual exploratory conversations (interviews) to investigate in-depth the experience of staff, patients, and families - particularly:
  - Design of risk reduction/safety plans and service user and family involvement
  - The confidence families have to contact a service user's care team
  - The ease with which the family/carers of a service user can contact the care team
  - The responsiveness of the care team as experienced by the family/carer

### **Recommendation 3**

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

## 1 Introduction

### 1.1 Why was an independent review commissioned?

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

In line with The Serious Incident Framework for England 2015, (appendix 1) <sup>2</sup>. The guidance says

“The regional investigations team should commission an independent investigation of mental health care related homicides when a homicide has been committed by a person who is, or has been, subject to a care programme approach, or is under the care of specialist mental health services, in the past 6 months<sup>49</sup> prior to the event.”

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

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

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

### 1.2 The approach taken

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

### 1.3 An overview of what happened and relevant background information

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<sup>2</sup> <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framework-upd.pdf>

On 26 March 2019, Mr F stabbed a member of the public who was known to him. The knife pierced the victim's heart and he died of his injury. At trial, the judge accepted there had been no intention to kill but there had been an intention to cause serious harm. The trigger for the fatal assault appeared to be related to money reportedly owed to Mr F by the victim.

At the time of the fatal assault Mr F had 20 previous convictions. These included drug related offences and violent offences. He also had a documented history of gun related crime, weapons use, and a chaotic lifestyle history.

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

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

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

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

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

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

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

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

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

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

1 **2 Terms of reference or key line of enquiry**

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

3

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

6

7 The independent review will include:

8

- 9 • The sourcing and review of relevant documents to develop a comprehensive  
10 chronology of events, against which the internal investigation’s findings will be  
11 considered.
- 12
- 13 • Interviews with appropriate personnel where necessary to provide additional  
14 supporting information.
- 15
- 16 • Critical analysis of the internal investigation’s key lines of enquiry and whether  
17 these were appropriate, adequately considered and explored, and highlighting  
18 any areas requiring further investigation.
- 19
- 20 • The review and assessment of compliance with local policies and national  
21 guidance, including the application of the Duty of Candour and statutory  
22 obligations including safeguarding.
- 23
- 24 • Thorough review of the clinical records; assess the care and treatment  
25 received by Mr F including review of the adequacy of risk assessments, risk  
26 management, and care planning including carers’ assessment.
- 27
- 28 • Explore whether Mr F’s family had alerted professionals to any mental health  
29 concerns and, if so, how this was acted upon.
- 30
- 31 • Review the appropriateness of the treatment of the service user in the light of  
32 identified health and social care needs, identifying both areas of good practice  
33 and areas of concern.
- 34
- 35 • Identify any gaps or omissions in care not adequately addressed within the  
36 investigation commissioned by South West Yorkshire Partnership NHS  
37 Foundation Trust.
- 38
- 39 • Constructively review information shared and communications between  
40 treatment teams, identify any gaps and potential opportunities for  
41 improvement, and make appropriate recommendations.
- 42
- 43 • To identify any areas of best practice, opportunities for learning, and areas  
44 where improvements to services are required with a focus on the period from  
45 2013 to the date of the incident.”

46

47

1 In addition, the independent team were tasked with:  
2

- 3 • Assessing the reasonableness of the original internal investigation in terms of  
4 method and methodology.  
5
- 6 • Assessing and reporting on the progress made against the implementation  
7 and effectiveness of the recommendations from the internal investigation.  
8
- 9 • Identifying any notable areas of good practice or any new developments in  
10 services resulting from the implementation of the recommendations.  
11
- 12 • Considering any partially implemented recommendations and identifying  
13 possible organisational barriers to full implementation, providing remedial  
14 recommendations as appropriate.

1 **3 Communication with Mr F and his family**

2  
3 Initial contact was achieved between Mr F's family and CUK on 10 January 2022.  
4 This was followed by a face-to-face meeting via Microsoft Teams on 24 January. It  
5 was clear at that meeting that Mr F's family felt let down by South West Yorkshire  
6 Partnership NHS Trust. This sense of feeling let down was mostly because of a lack  
7 of proactive communication with Mr F's mother prior to the incident leading to this  
8 independent review and the absence of communication after the incident.

9  
10 The lack of communication meant the Trust had no appreciation of:

- 11
- 12 • The personal cost to Mr F's mother because of the active support she
- 13 provided to her son.
- 14
- 15 • The fact that neither Mr F's sister, nor his mother, had been given sight of the
- 16 Trust's internal report prior to, nor after, its acceptance as a completed report.
- 17
- 18 • The concern held by Mr F's sister about her brother's contemporary wellbeing
- 19 in prison, and her concerns about his mental health and whether he was
- 20 receiving effective treatment by in-reach mental health services.
- 21
- 22

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

28  
29 Between January 2022 and the completion of the interim report, CUK maintained  
30 contact with Mr F's sister by email, updating her regarding progress in the  
31 independent process and any delays in projected timescales.

32  
33

## 1 4 Synopsis of the patient journey leading to the incident

### 2 3 4.1 Historical overview

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

9  
10 In September 2013, a clinical psychologist who had assessed Mr F on 16 occasions  
11 compiled a report based on these assessments. Much of its content is not relevant to  
12 this independent process. However, the following excerpt is:  
13 “Risk to others lies in his criminal activity and violence. Criminal activity more likely if  
14 he does not have a range of pro-social activities and contact with others, he gets  
15 bored and wants a buzz and gets involved in drug misuse. The risk of violence is  
16 increased if unwell and likely to make paranoid interpretations of other’s behaviour. It  
17 noted that his limited reliance on others and sense of shame about illness will  
18 complicate attempts to prevent future relapse<sup>3</sup>.”

19  
20 When Mr F was discharged from the centre and returned to his own home, he was  
21 initially seen weekly and his medication was via depot injection. His outlook was  
22 positive. One month later, a family member raised concerns about possible illicit drug  
23 use but there were no discernible features of this in Mr F’s mental health  
24 presentation.

25  
26 Over the early period of his discharge from the Bretton Centre, Mr F engaged in  
27 regular illicit drug screening. These urine tests were negative for drugs.

28  
29 At his outpatient appointments, Mr F was assessed as stable and confirmed his  
30 abstinence from illicit drugs.

31  
32 At an outpatient review in March 2014, it was decided that Mr F’s community  
33 treatment order would be renewed even though he was stable. A social  
34 circumstances report in April 2014 confirmed this decision was a prudent one.  
35 The same month (April 2014), his continuing stability, combined with the protective  
36 nature of the Community Treatment Order, led to the decision that Mr F should  
37 transfer to local services within the next six months. At this juncture, he was living full  
38 time at his mother’s address, visiting his own address on a limited basis. Mr F had  
39 also applied for a council property near the centre of Huddersfield and was seeing  
40 his partner and son twice a week at his mother’s home.

41  
42 In June 2014, a reduction in Mr F’s dosage of Paliperidone to 50 per month (via  
43 depot injection) was agreed to alleviate its sedating side effect. Mr F reported a  
44 beneficial impact a month later.

45  
46 By September 2014 Mr F and his then consultant psychiatrist agreed to home visits  
47 at his mother’s address every other week, and to attend as an outpatient three times

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<sup>3</sup> Taken from page 23 of the internal investigation report compiled by Professor J Shaw.

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

5  
6 The concern regarding medication non-compliance was the primary reason for the  
7 consultant psychiatrist to recommend to hospital managers that Mr F remained on a  
8 community treatment order. He also recommended that Mr F should be managed by  
9 an assertive outreach team and not general adult community services. This was  
10 initially accomplished.

11  
12 However, in December 2014, because Mr F was stable in his presentation and  
13 engaging well with the team, referral to a community mental health team was  
14 deemed appropriate as he no longer met the criteria for assertive outreach.

15  
16 The community treatment order for Mr F was also renewed in December 2014.

#### 17 18 **4.2 Overview of the four years leading to the incident**

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

24  
25 An excerpt of the risk history handed over states:

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

35  
36 The plan at this stage was to hold visits with his care coordinator as well as  
37 outpatient visits with his new consultant psychiatrist on alternating weeks.

38  
39 Within three months of transferring to a community mental health team, Mr F was  
40 complaining about his medication and attributing it to his low mood, occasional  
41 suicidal thoughts, variable sleep, and occasional paranoid ideation.

42 On 20 July 2015 he expressed concern that his "girlfriend was seeing other men" .  
43 According to the internal report written by Prof Jenny Shaw: "It was thought this was  
44 not delusional, [and it was noted that Mr F] discussed this insightfully about his  
45 diagnosis and treatment"<sup>5</sup>.

46  

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<sup>4</sup> Taken from the internal investigation report written by Professor J Shaw – page 25

<sup>5</sup> From the internal report written by Prof Jenny Shaw page 26

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

5  
6 In August 2015, his new consultant psychiatrist recommended the community  
7 treatment order be retained as Mr F had reported it was unlikely that, without it, he  
8 would continue to comply with his medication. The report compiled for hospital  
9 managers by this consultant also reported that Mr F was concerned about his  
10 jealousy towards his partner and questioned whether it might be delusional. The  
11 conditions for the removal of a community treatment order were clearly not in place.

12  
13 During the subsequent month, Mr F reported that the introduction of an anti-  
14 depressant had helped his mood. He also reiterated his request that there was to be  
15 no contact with his mother. This same month, his community psychiatric nurse talked  
16 with Mr F about his non-engagement in the community and encouraged him to have  
17 face to face contact with the treatment/care team.

18  
19 In early October, Mr F's sister raised a concern about possible illicit drug use, a  
20 deterioration in her brother's mental health, and possible paranoid behaviour. The  
21 next day, a mental health worker found Mr F was not at home when he visited. The  
22 health professional then went to Mr F's mother's home and found him there. He  
23 agreed to go with the health professional for his depot injection. Mr F was noted to  
24 be unkempt.

25  
26 On 14 October, one week later, Mr F's community psychiatric nurse noted:  
27 "low in mood, deteriorate in self-care, uncooperative, defensive as to why he had not  
28 kept several appointments, agreed to home visits at mother's address, denied illicit  
29 drug use, urine sample taken, said he didn't agree with the CTO, did not want to  
30 appeal it, continued to withhold consent for mental health services to speak to  
31 mother, sister or ex-partner."<sup>6</sup>

32  
33 One month later, Mr F reported he would not tell his care team if he were using illicit  
34 drugs and continued to withhold consent for the team to contact his family.

35  
36 By December 2015, Mr F was feeling happier. He had started running. He reported a  
37 stable mood.

38  
39 In February 2016, his regular community psychiatric nurse had an extended period  
40 of leave from work. At an appointment with his community consultant psychiatrist, Mr  
41 F also reported he was uncomfortable around people, that he found his depot helpful  
42 and would continue with it if not on a community treatment order. It was agreed that  
43 visits would take place once every three months.

44  
45 Mr F remained stable, and a decision was made to reduce his depot injection  
46 (Paliperidone) prior to the review and renewal of his community treatment order. It  
47 was also decided that a recommendation would be made to continue with the  
48 community treatment order because of the reduction in depot medication. If Mr F

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<sup>6</sup> Excerpt from internal investigation report written by Professor J Shaw

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

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

- 4
- 5 • No psychotic symptoms since being referred to general adult services in
- 6 March 2015
- 7 • Reliable at his attendance at outpatient appointments
- 8 • Reasonably reliable with his anti-depressant medication
- 9

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

15

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

21

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

29

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

32 The notes made by this new psychiatrist included:

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

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

---

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

1  
2 One month later, Mr F and the same consultant psychiatrist discussed medication at  
3 length, resulting in the decision to continue his depot injection. Mr F was  
4 disappointed in this outcome. Taking longer intervals between injections was offered  
5 as an option, but Mr F was unwilling to accept that outcome also. The consultant  
6 determined that depot was the only option available but would consider changing to  
7 oral medication once Mr F had recommenced sertraline and that it had demonstrably  
8 achieved stability.

9  
10 A salient excerpt from the clinical record states:

11 Mr F “described that he continued to have anxiety which is long standing when he is  
12 out and about in crowded places and avoids socialising. Feels people are watching  
13 and talking about him when he’s in the community, visits mother regularly. Not much  
14 motivation to do things because of depot injection, asked about the risk of stopping  
15 meds he said his anxiety and paranoid [sic] could get worse. Said he would engage  
16 with the team and take oral meds. [The] [community psychiatric nurse] said she  
17 would liaise with GP surgery. [They] informed [that Mr F] was not picking up his  
18 Sertraline. [He] said he had not gone because he used to get it delivered to his  
19 house and he did not like going to GP as he felt anxious”<sup>8</sup>.

20  
21 In the first week of November, Mr F’s GP wrote to the community consultant  
22 psychiatrist alerting him to the fact that Mr F’s depot was three-weeks overdue, and  
23 that Mr F did not want it. Mr F had asked for Risperidone and the GP had prescribed  
24 this as an alternative. It should be noted that as Mr F was no longer on a community  
25 treatment order, denying his request for oral medication was no longer an option.

26  
27 By 17 November Mr F had not attended at his GP surgery for further Risperidone.  
28 On this day he would have run out of the medication with which he had been  
29 provided. The clinical record states, “this demonstrates his ongoing poor  
30 concordance with medical treatment”.

31  
32 On 29 November, Mr F reported to his community consultant psychiatrist that  
33 Risperidone did not work for him and that he wished to try Aripiprazole. This request  
34 was approved.

### 35 36 **Fourteen months leading to the incident of violent assault with intent to wound**

37  
38 On 17 January 2018, six weeks after Aripiprazole was commenced, Mr F was not  
39 available for a scheduled home visit.

40  
41 On 21 March 2018, a further eight weeks later, the community psychiatric nurse was  
42 unable to confirm with the GP surgery whether Mr F was collecting his medication.

43  
44 On 4 April 2018, successful contact with Mr F was achieved. He reported that  
45 Aripiprazole was much better than the depot injections he had previously received.  
46 At this care contact, Mr F was also introduced to his new care coordinator and  
47 arrangements were made for a follow up medical assessment. However, Mr F did

---

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

<sup>8</sup> Excerpt from internal investigation report written by Professor J Shaw

1 not attend this session which was scheduled for 18 April. He also did not attend on  
2 24 May 2018.

3 Contact was not achieved until 18 June when he was assessed by his new care  
4 coordinator. At this meeting no concerns were noted.

5  
6 On 1 July 2018, the care coordinator again achieved successful contact with Mr F,  
7 and he was noted to be taking his medications. The clinical records also note that Mr  
8 F confirmed to this professional that he had not taken illicit drugs for many years and  
9 did not drink alcohol.

10  
11 The following day he was assessed by his consultant psychiatrist. The record  
12 included the following information:

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

22  
23  
24 Between July 2018 and December 2018, the clinical records recorded a period of  
25 stability for Mr F, with reasonable compliance with medication and regular contact  
26 with his mother. Mr F's request that there was to be no contact with his family  
27 remained.

28  
29 This presentation of stability continued until the day of the incident on 30 March  
30 2019.

## 1 **5 Findings**

2

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

6

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

11

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

14

- Mr F's clinical records

15

- Professor Shaw's report

16

- A constructive critique of the relevant policies and procedures in place at the  
17 Trust when Mr F was in receipt of care and management (see appendix 1)

18

### 19 **5.1 Mr F's diagnosis**

20

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

22

### 23 **5.2 Risk Assessment and Risk Management**

#### 24 **Trust policies and procedures of relevance to Mr F's risk assessment and risk 25 management:**

26

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

34

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

37

#### 38 **Relevant historical knowledge about Mr F's risks**

39

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

45

46

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

- 4
- 5 • Six driving offences
- 6 • Eight offences of theft and burglary
- 7 • Seven drug related offences
- 8 • 15 offences relating to the court (i.e., breaches of orders)
- 9

10 In addition, he had two convictions for offences against a person, namely Assault  
11 Occasioning Actual Bodily Harm (AOABH). One occurred in 1996 and one in 2011  
12 for an offence of battery against his partner.<sup>9</sup> The context of the first incident was Mr  
13 F, alongside an accomplice, assaulted a man while he was sitting in his car. Mr F  
14 broke the victim's arm with a piece of wood. The defence provided was that the  
15 assaulted individual had been picking on Mr F's friend.

16 Regarding the second incident (2011), the context given was that his partner had  
17 arrived at Mr F's flat to pick up their son. He got into the car with her and attacked  
18 her by grabbing her face, neck, and hair. Minor physical injuries were sustained.

19

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

24

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

27

28 This 2013 risk assessment identifies a history of serious substance misuse. Drugs  
29 used included cannabis from the age of 14, and heroin and crack cocaine in his early  
30 20s. There was some evidence suggesting the use of class A drugs prior to this.

31

32 The assessment conducted up to and including 2013 retained its relevancy between  
33 2014 – 26 March 2019.

34

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

---

42

43

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

1 **5.2.1 Areas where the patient record demonstrated compliance with good**  
2 **practice in risk assessment and management principles as set down by the**  
3 **Royal College of Psychiatrists<sup>10</sup>**  
4

5 The clinical records make clear that Mr F's risks were well documented and  
6 understood, up to and including the time he was discharged from the low secure  
7 mental health service and its community service to general adult services.  
8

9 Then, between 2016 and 2017, the reluctance of the general adult community team  
10 to rescind Mr F's community treatment order demonstrates sustained awareness of  
11 the significant risk presented by his potential disengagement from the team and non-  
12 compliance with his medication. The records indicate an awareness that avoiding  
13 rescinding the community treatment order was a non-viable option. The team's  
14 approach of encouraging Mr F to demonstrate stability and responsibility, as  
15 suggested in the records, is indicative of their understanding that careful control and  
16 optimisation of the community treatment order in place was necessary to embed  
17 healthy behaviours in Mr F.

18 Mr F reported openly that, had he not been subject to a community treatment order,  
19 it was unlikely he would have remained compliant with any treatment plan. This  
20 conviction softened and disappeared in 2017.  
21

22 Excluding a brief period of sporadic contact with Mr F toward the end of 2017 and  
23 early 2018, the community mental health records also reveal a reasonable level of  
24 testing for substance misuse, and that alcohol and illicit drug usage were regular  
25 features of clinical conversations with Mr F.  
26

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

30 The independent nurse listed the following:

- 31 • Risk management must be built on recognition of the service user's strengths  
32 and should emphasise recovery. In the case of Mr F, this is demonstrated by  
33 the assessments leading to and planning for Mr F to step down from forensic  
34 services to the assertive outreach team, and then to the general adult  
35 community mental health team. This expectation was also exhibited by the  
36 short time he spent receiving the support of the assertive outreach team.
- 37 • Awareness that risk cannot be eliminated, yet can be assessed, managed, or  
38 mitigated. The level 2 Sainsbury's risk assessment conducted on 19 March  
39 and 18 September 2013 clearly demonstrates a comprehensive assessment  
40 of the risks posed by Mr F. It identifies the following risk management  
41 activities:

42 Positive Risk-Taking Options (and support needed)

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

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

---

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

1           ▪ Currently detained under section 37 MHA  
2 Relapse Indicators/Relapse 'Signatures' (for example, inability to sleep,  
3 substance misuse)

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

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

- 9           ▪ Currently an inpatient
- 10          ▪ Increased level of nursing observations
- 11          ▪ Reconsider use of leave

12 Crisis Plan (Short-Term Crisis Management Options):

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

16 Long-Term Risk Management Options

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

20 Responsibilities for Actions (including timescale and/or dates)

- 21          ▪ Multidisciplinary

22  
23 Similarly, in January 2016, the Sainsbury's Level 2 risk assessment was  
24 comprehensively completed with the following risk management plan.

25  
26 Positive Risk-Taking Options (and support needed)

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

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

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

34  
35 Relapse Indicators/Relapse 'Signatures' (for example, inability to sleep,  
36 substance misuse)

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

42  
43 Contingency Plan (Actions required to reduce risk of crisis situations  
44 developing)

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

49  
50 Crisis Plan (Short-Term Crisis Management Options):

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

5

6           Long-Term Risk Management Options

- 7           ▪ Continued engagement with Mental health services
- 8           ▪ Depot medication

9

10          Responsibilities for Actions (including timescale and/or dates)

- 11          ▪ Multidisciplinary

12

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

17

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

21

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

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

30

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

35

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

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

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

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

- 3
- 4 • Mr F’s records indicate that, until his community consultant retired in 2016, the  
5 community team had taken a cautious approach to his many requests that his  
6 community treatment order be rescinded. This is particularly clear given the  
7 context of his stated belief that he only complied with his mental health  
8 medication plan and maintained contact with mental health services because  
9 of the community treatment order in place. His candid articulation that he  
10 might disengage with services if the community treatment order were  
11 removed supports the appropriateness of this caution and the deferment of  
12 this decision for as long as possible. Maintaining the community treatment  
13 plan in the longer term would not have been viable for mental health services.  
14 The circumstances of its imposition (i.e., transfer into forensic services from  
15 the prison population) were unique. Had he not required a secure placement  
16 because of his conviction, it is unlikely that a psychiatrist working with the  
17 general adult population in the community would have instituted this based on  
18 the circumstances of Mr F’s crime and criminal conviction. Furthermore, by  
19 the time the community treatment order was removed, Mr F had altered his  
20 position to one of confirming treatment compliance, as opposed to unwavering  
21 adherence to non-compliance. The decision to rescind it was reasonable.  
22
- 23 • The assessment and management of Mr F’s forensic past: Mr F’s forensic  
24 history makes concerning reading for most lay persons; however, in the  
25 context of violent crime and dangerous behaviours, Mr F’s forensic history did  
26 not convey a blatant risk of harm to others. It would have been a sizable leap  
27 in analysis to consider him a homicide risk. Divergence from his mental health  
28 care plan and medication carried a predictable risk that he would revert to  
29 previous behaviour patterns, including class A drug usage.  
30
- 31 • A collaborative approach to risk management was particularly evident within  
32 the community forensic team  
33  
34

### 35 **5.1.2 Areas where the CUK independent clinicians considered practice did not** 36 **meet the standards expected**

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

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

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

### 32 **5.3 Mental health care, management, and treatment**

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

#### 36 **5.3.1 Medication management**

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

45  
46 At the point the community treatment order was rescinded it was only a matter of  
47 time before Mr F would request switching from depot to oral medication. It is the  
48 independent perspective of the psychiatrist providing clinical advice to CUK that,

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

9  
10 Regarding the type of depot Mr F was prescribed and the subsequent oral  
11 medication of Aripiprazole, the clinical advisors have no criticism. Neither did  
12 Professor Shaw criticise this aspect of Mr F’s management. The choice of  
13 Aripiprazole was reasonable in view of its side-effect profile after Mr F complained of  
14 stiffness on Risperidone (he had also previously had a dystonic reaction with  
15 Clopixol).

16  
17 Regarding the care team’s efforts to assess medication compliance and risk: This  
18 was not an issue while Mr F was on depot medication and on a community treatment  
19 order. However, these safeguards ceased in 2017. Achieving a robust assessment  
20 of this is hampered by sparse recordkeeping. Nevertheless, there are records that  
21 show Mr F’s then consultant psychiatrist discussing the risk of stopping medication  
22 with Mr F on 30 October 2017 while, from time to time, the care coordinator records  
23 mention checking medication compliance. There is also evidence of checking with  
24 the GP about issuing Mr F with prescriptions, and on 15 January 2019 Mr F was  
25 escorted to collect his prescription.

26  
27 Between November 2017 and April 2018 there is a significant gap in Mr F’s care  
28 regarding contact visits and oversight. Although changes in medication may not have  
29 been indicated, the CUK team would have expected evidence of a greater degree of  
30 clinical concern about him than is evidenced by the clinical record. Mr F had stopped  
31 his depot medication in the Autumn of 2017. This gap in contact was remedied in  
32 April 2018, when monthly outpatient contact was reinstated (see next sub-section  
33 about Care Planning).

34  
35 The clinical team, on a justifiable risk management basis, could over this time have  
36 considered seeking information from Mr Fs family, particularly his mother. We know  
37 from speaking with her daughter that Mr F’s mother took every opportunity to invite  
38 her son to her home, providing meals and wider family contact. She would have  
39 been a good source of information regarding the wellbeing of her son, and it would  
40 have created a vehicle for her to raise any concerns she may have had about his  
41 wellbeing.

42  
43 Technically, initiating a doorstep challenge at Mr F’s registered address would have  
44 been a reasonable intervention. However, because he never invited health  
45 professionals or his family to his home it is uncertain whether such a strategy would  
46 have been successful.

47  
48 From April 2018, the clinical notes, though brief, show that Mr F was asked about  
49 medication compliance at these appointments and was supported in obtaining his  
50 script from his GP surgery in January 2019. Checks were also made with Mr F’s GP

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

### 6 **5.3.2 Care planning**

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

12  
13 However, in terms of frequency of contact and the way the mental health  
14 professionals tried to engage with Mr F, this was reasonable. Monthly contact with  
15 this type of service user, one who was assessed as stable, was in line with practice  
16 expectations. Furthermore, when Mr F did not attend his appointments, there is a  
17 consistent pattern of follow up with him about this and appointments are re-  
18 scheduled.

19  
20 The independent analysis<sup>11</sup> of Mr F's clinical records shows his engagement with  
21 any plan initiated by mental health teams was limited. This low to no engagement on  
22 behalf of Mr F is something that was unsurprising to his family. They believe Mr F did  
23 not accept his mental health illness and preferred to maintain a strict code of privacy.  
24 He refused to divulge his private thoughts or reveal challenges he was experiencing  
25 to health professionals or his family.

26  
27 The CUK independent team have no criticism of the care plan for Mr F. Once Mr F's  
28 community treatment order was rescinded, he was free to engage or to not engage.  
29 There were no indications that he lacked capacity to make his own decisions,  
30 regardless of whether they were wise decisions. CUK's independent consultant  
31 psychiatrist is of the view that the clinical team did well to try and follow up with Mr F  
32 as often as they did (except between November 2017 and April 2018), and to have  
33 achieved the level of contact with him that they did.

### 34 35 **5.4 The community treatment order**

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

40  
41 Professor Shaw's report stated:

42 Treatment

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

---

<sup>11</sup> By Professor Shaw and CUK

1 aggression' and in a Report for Manager's Hearing, [the psychiatrist] noted 'seems to  
2 have good insight into his illness, accepts the need for treatment but blames depot  
3 for lethargy and poor motivation, without CTO there would be a likelihood of stopping  
4 medication with high risk or relapse, is too early to discharge from CTO'.  
5

6 "On 25/09/17, [Mr F] denied a history of non-compliance but said if he wasn't on a  
7 CTO, he wouldn't take his depot. On 23/09/13 [the] clinical psychologist said [Mr F's]  
8 coping style is one of independence not relying on others; it is exacerbated when he  
9 is unwell. It is likely that if he were to recognise the first symptoms of mental ill  
10 health, he would be unlikely to talk to a professional. He was also unwilling to accept  
11 that he may become unwell again. Risk to others lies in his criminal activity and  
12 violence. Criminal activity is more likely if he does not have a range of pro-social  
13 activities and contact with others, he gets bored and wants a buzz and gets involved  
14 in drug misuse. The risk of violence is increased if unwell and likely to make  
15 paranoid interpretations of other's behaviour. [The clinical psychologist] noted that  
16 [Mr F's] limited reliance on others and sense of shame about his illness will  
17 complicate attempts to prevent future relapse.  
18

19 "The CTO was rescinded because he was symptom free and compliant with  
20 treatment. This was in keeping with Mental Health Act Code of Practice Guidance  
21 which indicates that the least restrictive option in relation to care should be pursued.  
22 In my opinion, the rescinding of the CTO should have been accompanied by a  
23 review of risk and the risk management plan<sup>12</sup>. In view of previous concerns about  
24 compliance, the team should have ensured that their subsequent monitoring of [Mr  
25 F's] care was sufficient to establish any change in presentation. This should have  
26 included contact with the family to give them clear guidance on how to liaise with  
27 services if they had concerns."  
28

29 The CUK team agree with Professor Shaw's consideration about the community  
30 treatment order and concur with her opinion that a more robust risk management  
31 and crisis intervention plan should have been formulated. Inclusion of Mr F's family  
32 should also have been part of this plan. It was essential that they were aware of this  
33 for their own safety and wellbeing, alongside their wish to support Mr F and optimise  
34 his wellbeing.  
35

36 Good practice is to construct risk management plans and crisis intervention in  
37 partnership with the service user. In this case, all the indications are that Mr F would  
38 not have participated in this on anything other than a superficial level.  
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<sup>12</sup> The evidence gathered by the original investigation team was destroyed, and frontline staff can no longer recall why their practice standards were not as they should have been. CUK knows from previous cases reviewed at this Trust that the style of documentation used was an impediment to accurate record keeping. The Trust has now completely re-designed this so documenting risk assessment is easier to accomplish, and easier to review and track.

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## 5.5 Family engagement

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

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

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

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

### 6.5.1 Engagement of Mr F’s family after the 2019 incident

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

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

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

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

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

## 6 Summary of identified learning opportunities and improvements made

Professor Shaw's 2019 report stated:

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

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

- Risk Assessment and contingency planning, including:
  - The accuracy of risk assessment documentation in terms of relevant historical context, contemporary information, and key dates.
  - The depth of risk contingency plans and crisis intervention plans, especially where it is known and predictable that a significant but necessary change in a care plan may diminish the engagement of the service user with the mental health service and/or their medication.
  - The engagement of involved family members (carers and close social support network) in ensuring the risk assessment and management plan is comprehensively informed. This is particularly the case when a family is willing to provide information.
- Family engagement:
  - A service user's reluctance for mental health professionals to share information with those who are providing meaningful input and support does not preclude, firstly, the service from engaging with those individuals to hear what information they wish to share or, secondly, to ensure that they are aware of who to call for assistance/help both in normal working hours and outside of normal working hours.

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

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

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

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

4  
5 Mr F's sister has agreed to sit on the interview panel and the interim assistant  
6 director of nursing, quality and professions is currently working with recruitment and  
7 HR to arrange for the sign off of the job description.

8  
9 **Note:** CUK recommends that the Trust draws on the principles of Restorative Justice  
10 and restorative processes in shaping the job profile, and includes the competencies  
11 of its family liaison officers. It should not, in CUK's view, replicate the police model,  
12 which is for an entirely different purpose than what is required in the NHS after  
13 incidents of harm.

14  
15 The Trust has also developed a clear and well designed information leaflet for family,  
16 friends, and carers of service users. The three commitments it has published are:

17  
18 **1: We will work with you as a partner**

19 This means we will:

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

25  
26 **2: We will support you to get help and assistance when you need it**

27 This means we will:

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

33  
34 **3: We will train our staff to be aware of carers' needs**

35 This means we will:

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

39  
40 CUK anticipates the Trust will measure its performance against these commitments  
41 going forward.

42  
43 Regarding additional learning reflections: There was one point where Mr F  
44 expressed concerns about his then girlfriend (2015). He had previously assaulted a  
45 previous girlfriend in 2011. No safeguarding concerns were identified or acted on in  
46 2015. Now the independent review team would expect a safeguarding response as  
47 the Trust has implemented an educational programme for its staff regarding  
48 domestic abuse and staffs' responsibilities about this. The reviewed risk assessment  
49 tool is also more robust and more likely to enable contemporary awareness of such

1 issues, unlike the risk assessment tool utilised at the time Mr F was a service user  
2 with the Trust.  
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4

## 1 **7 Outstanding actions/recommendations required**

2  
3 The Trust can show that it has acted on all the action points set down in its action  
4 plan constructed following its own internal investigation. The Trust's new approach to  
5 risk assessment, FIRM, is intended to address all the risk management practice and  
6 documentation concerns highlighted by its own investigation, this independent  
7 investigation, and other investigations (internal and independent).  
8 The recommendations below seek to address what CUK considers to be outstanding  
9 issues, and/or the need for auditable assurance that the actions already taken have  
10 delivered the improvements they were designed to achieve.

### 11 12 13 **Recommendation 1:**

#### 14 **What is required:**

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

#### 25 26 **Why must this be achieved?**

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

#### 31 32 **To reduce the risk of:**

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

### 38 39 40 **Recommendation 2:**

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

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

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

- 1
- 2 • Focus groups of professionals, service users and families
- 3 • Peer review of record keeping, assessing content and quality of what is
- 4 written
- 5 • Individual exploratory conversations (interviews) to explore in-depth the
- 6 experience of staff, patients, and families particularly:
- 7
- 8     ▪ Design of risk reduction / safety plans and service user and family
- 9 involvement
- 10     ▪ The confidence families have to contact a service user's care team
- 11     ▪ The ease with which the family/carers of a service user can contact
- 12 the care team
- 13     ▪ The responsiveness of the care team as experienced by the
- 14 family/carer
- 15

### 16 **Why must this be achieved?**

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

### 22 **To reduce the risk of:**

23 Avoidable repetition of the concerns raised by this independent process and the  
24 Trust's own internal investigation.

### 25 **Recommendation 3**

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

### 33 **Why is this recommended:**

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

### 39 **To reduce the risk of:**

40 The Trusts good intentions and much needed investments in this area falling short of  
41 what is required.

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## 8 Conclusions

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

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

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

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

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

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

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

1 **9 Appendices**

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

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

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