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South Cumbria
Community Safety
Partnership

Joint Domestic Homicide Review and independent mental health homicide investigation in South Cumbria

March 2023

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Our Report has been written in line with the Terms of Reference as set out in the independent investigation into the care and treatment of a 28-year-old man in South Cumbria. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events that may occur outside of the timescale of this review will render our report out-of-date. Our Report has not been written in line with any UK or other overseas auditing standards, we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. However where there is evidence that the information is not accurate, this has been made clear in the report and in relation to all other information received from organisations and individuals, a factual approach has been adopted with discrepancies and variances in accounts highlighted where known.

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1. Preface

This joint Domestic Homicide Review (DHR) and NHS England mental health homicide independent investigation was carried out following the death of Mr M and concerns the mental health care and treatment of his son Mr D. We wish at the outset to express our deepest sympathy to the family of Mr M.

This review has been undertaken in order that lessons can be learned; we appreciate the engagement of the family throughout this difficult process.

We would like to thank those involved for their time and valuable input throughout this review process.

We would also like to thank staff within all agencies that have contributed to this review.

This has been the second statutory homicide review carried out in South Cumbria.

South Cumbria Community Safety Partnership and NHS England (North) agreed in July 2019 to commission a joint review.

It was agreed that the circumstances of Mr M's death met the criteria of Section 9 (3) (a) of the Domestic Violence, Crime and Victims Act (2004) and a mental health independent homicide investigation within the NHS England Serious Incident Framework (March 2015) and Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

Family statements

Family statement - Mr M's brothers

Since the tragic death of our brother Mr M our lives have changed beyond belief and without the tremendous support of all our friends, family and support agencies we would never have got through this last 18 months. Whilst we realise mistakes have been made, we also realise that most of these mistakes could have been avoided and hopefully measures can be taken to make sure it never happens again.
The whole family has been left devastated by the loss of Mr M, he was a very sociable and well-liked man, he would help anyone he came into contact with and is missed everyday by all his family and friends. Myself and my two remaining brothers have lost our eldest brother, best friend and will have to live with this but we would like to thank everyone who has helped us, supported us and have carried out the investigation into the whole incident.

Family statement - Mr D's mother

I was asked to write a witness impact statement on behalf of me and my family. To be honest I am finding it very difficult to articulate everything I feel and want to say.

On that evening in June 2019, our lives were changed forever and in the most dreadful and traumatic way. What makes it even more difficult to reconcile is that the death of Mr M was wholly avoidable had mental health professionals trusted with the care of our son had really listened to what we, as parents, were saying to them. Our lives will never be the same, our sense of normal has forever shifted. I have lost my former husband, friend and co-parent of our son, my family have lost a good friend. Mr D has lost his father, who he was very close to growing up. His life opportunities have been limited and he will now probably spend much of his life in an institution. Mr M's brothers and their families have lost their eldest sibling, friend and Uncle. And all this entirely avoidable.

I very much hope that no future family has to go through what we have. But in order for this to happen hospitals and institutions really need to take a good look at themselves. Fully understand that their acts and omissions can have a devastating impact on families. They need to recognise that parents, families and carers will generally have insightful and useful information that can be used and not disregarded.

I would like to thank my son's care coordinator for the care and support she provided to him and to Mr M and I. They were supportive and professional

RIP Mr M.

Contents

2. Introduction

2.1 This joint review examines the circumstances surrounding the death of Mr M, a 70-year-old male resident of Walney, Cumbria. Mr M was killed by his 28-year-old son Mr D, at his son's address in Barrow-in-Furness in June 2019. The joint review includes a review of the care and treatment of Mr D by NHS services.

2.2 Mr D's mother (Mrs L) had called at the house to check on Mr D and had found Mr M lying at the foot of the stairs, with Mr D on the phone to the ambulance service. Mrs L took over the call to the ambulance service and asked them to attend. North West Ambulance Services (NWAS) attended at approximately 6.34pm, and met his mother and Mr D, who had blood on his clothes. They saw Mr M lying at the foot of the stairs, saw that he was very pale with wounds to his body. Time of death was recorded as at 6.42pm.

2.3 Cumbria Constabulary received a call from NWAS at about 6.30pm in mid-June 2019 reporting that there was a man (Mr M) who had been attacked at Mr D's home in Barrow-in-Furness and that he was not breathing. Mr D was taken into custody, arrested on suspicion of murder and interviewed that evening at Barrow Police Station.

2.4 This case is about the homicide of Mr M, and the perpetrator of the homicide, his son Mr D. As far as the panel can ascertain, there is no pattern of domestic abuse known to agencies prior to the homicide. However there are instances where Mr D had made threats towards Mr M when he was mentally unwell, and one incident towards his stepsister in 2012.

2.5 Mr D was first referred to community mental health services in Cumbria[1] in June 2018 by his GP. He was seen for assessment by the Access and Liaison Integration Service (ALIS).[2] After assessment by a consultant psychiatrist Mr D was accepted into the Early Intervention in Psychosis pathway (EIP). He was allocated a care coordinator (CCO) in June 2018. Mr D was also under the supervision of probation at this time, for an offence unrelated to Mr M or domestic abuse.

2.6 He was detained under Section 2 of the Mental Health Act (MHA)[3] in December 2018 to Hadrian Ward in Carlisle, and transferred to the Dova Unit, a mental health ward based on the Dane Garth site of Furness General Hospital, in January 2019. His presentation fluctuated and the overall assessment was that he was not improving, and he maintained he was not mentally ill. The clinical records include continued observations of him responding to unseen stimuli, smelling of cannabis, highly sexualised

[1] *Cumbria Partnerships NHS Foundation Trust; now Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust (CNTW).*

[2] *The Access and Liaison Integration Service (ALIS) provides assessment and support for people experiencing acute mental health distress and their carers. https://www.cntw.nhs.uk/services/access-liaison-integrated-service-alis-west/*

[3] *Section 2: Admission for assessment, up to 28 days. https://www.legislation.gov.uk/ukpga/1983/20/section/2*

behaviour and concerns about compliance with medication throughout his admission. He was detained under Section 3[4] MHA in January 2019.

2.7 Mr D remained an inpatient and went missing while on escorted leave with his mother in May 2019. He was found several days later in Blackpool, by his father Mr M who had gone to look for him. He was detained by officers of Lancashire Constabulary and taken to Victoria Hospital, Blackpool, for further assessment. While he was missing, a decision had been made by senior Trust staff that he should be admitted to a male Psychiatric Intensive Care Unit (PICU) when he was found, because of concerns about the risks he had presented.

2.8 The only male PICU bed available at the time was a Cygnet Health Care[5] Unit in Maidstone, Kent. Mr D was transferred from A&E to Maidstone on 26 May 2019, under Section 3 MHA. On 13 June 2019 his Section 3 was rescinded, and he was discharged and placed in a taxi to travel to Barrow-in-Furness. He arrived at his mother's address just after 3.00am on 14 June 2019. He committed the homicide four days later.

2.9 This report focusses on Mr D's contact with agencies from his first referral to community mental health services, with a detailed focus on the period from his first contact with community mental health services in June 2018.

2.10 The principal people referred to in this report are:

Person	Relationship	Ethnicity
Mr M	Father of Mr D	White British
Mr D	Son of Mr M	White British
Mrs L	Mother of Mr D	White British
Maternal grandparents	Parents of Mrs L	White British

2.11 This joint review will examine agency responses and support given to Mr M and his son, from Mr D's first contact with community services until the incident in June 2019. It will also examine events outside of this timeframe to identify any relevant background, and/or trail of abuse before his death.

2.12 It will look at whether support was accessed by either of them within the community and whether there were any barriers to accessing such support. By taking a holistic approach the review seeks to identify the appropriate solutions to make the future safer for others.

2.13 The key purpose for undertaking a domestic homicide review is to enable lessons to be learned. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in the homicide, and most importantly, what needs to change to reduce the risk of such a tragedy happening in the future.

[4] *Section 3: Admission for treatment, up to 6 months.* https://www.legislation.gov.uk/ukpga/1983/20/section/3

[5] *Cygnet Health Care is an independent provider of mental health care.* https://www.cygnethealth.co.uk/

2.14 This joint review has taken place alongside a criminal investigation which followed Mr D's arrest and subsequent charge for the murder of Mr M. This resulted in Mr D pleading guilty to manslaughter by diminished responsibility in December 2019, after the court was provided with psychiatric reports.

2.15 This joint review concentrates on the relationship between the individuals, seeking to establish whether domestic abuse was a feature of that relationship and if it was, to find that trail of abuse. Moreover, it seeks to look at what can be learned and what changes can be made to better protect others in the future. It will make recommendations that are cross agency or suggest a different approach that may better protect others.

2.16 The independent investigation follows the NHS England Serious Incident Framework[6] (March 2015) and Department of Health Guidance[7] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.17 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required to help prevent similar incidents occurring.

Events leading up to the homicide in June 2019

2.18 Mr D had been an inpatient at Cygnet Health Care, a mental health unit in Kent, since 26 May 2019. He was discharged at short notice on 13 June 2019 and arrived by taxi at his mother's house in Barrow in the early hours of the morning on Friday 14 June 2019. He then returned to live at his own address.

2.19 On the particular morning in June 2019, he phoned his father (Mr M) and asked if he wanted to spend the day together. He took his dog for a walk and Mr M collected him by car at about 1.30pm. They drove out to the coast to work on a boat with some friends. At around 3.30pm Mr M dropped Mr D back to the house where he had been living in Barrow.

2.20 After finishing work at around 5.00pm his mother went round to the house in Barrow to check on Mr D and see if he wanted to go for a walk with their dogs. Mr D was cooking some food that had been in the house for many months, since before he was admitted to hospital. When he was finished it was inedible, and he made some cereal instead. He decided not to go for a walk with his mother and she went back to her home.

2.21 At around 6.30pm she decided to go back to the house to check on Mr D. She knocked on the door and could hear shouting, she opened the door and saw

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[6] *NHS England Serious Incident Framework March 2015.* https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[7] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

Mr M lying on the floor at the foot of the stairs. Mr D was on the phone to the ambulance service.

2.22 The reports following the homicide indicate that there was a struggle and Mr M was attacked with a kitchen knife that had been in a drawer. Mr M was pronounced dead at the scene by ambulance personnel, and Mr D was arrested.

Findings and recommendations

2.23 We have made the following findings and recommendations for systems accordingly.

Finding 1 – **NHS Morecambe Bay CCG/GP**

Mr M's GP dealt with physical health issues, e.g. taxi licence health checks, and there were no serious physical or mental health concerns.

The GP service was provided within normal expectations.

Finding 2 – **NHS Morecambe Bay CCG/GP**

The GP dealt with physical health issues as they arose when Mr D was younger, making specialist referrals as appropriate.

Information was provided to prison health care services when requested as expected.

The GP responded to family concerns about Mr D's mental health, making onward referrals to secondary mental health services, and maintaining confidentiality as expected.

The Multi-Agency Risk Evaluation (MARE) minutes were received and content about risk noted, the internal process for GP review was followed. A safety alert was added to his notes due to the potential risk to self and others. A copy of the MARE notes was filed. There were no documented actions in relation to assessing any risks to family members, or to making a referral for a carer's assessment.

Prescribing of antipsychotic medication was taken on by the GP practice, without the support of a monitoring system to respond to compliance issues, which was not standard policy at the time for Primary Care.

Finding 3 – Cumbria Constabulary

The domestic incident involving Mr D and his stepsister in 2012 was investigated appropriately.

Following the Multi-agency Risk Evaluation (MARE) meetings, police protocols were followed to show how Mr D should be treated if he came into custody.

Police responded in a timely and proportionate way to concerns expressed by his uncle in June 2018, regarding the potential risk to his grandparents.

Lancashire Constabulary have reviewed protocols for patients when detaining an individual who has been absent without leave (AWOL) from detention under the Mental Health Act (MHA) to include provisions for when the patient is missing from outside of the Lancashire area and is not to be taken directly back to the place they are reported missing from.

Finding 4 – Cumbria and Lancashire Rehabilitation Company

Community Rehabilitation Company (CRC) supervision was provided within timescales, but formal risk assessment reviews should have been conducted as circumstances changed, such as address change and admission to hospital.

There was a lack of cross-agency communication, and information about mental health care and medication should have been clarified with professionals from the mental health services.

Risk information should have been updated and shared with other agencies.

Finding 5 – Cumbria County Council

Five Mental Health Act Assessments (MHAAs) were carried out between July 2018 and January 2019. Mr D was detained under Section 2 MHA in December 2018, and under Section 3 MHA in January 2019.

The family believe he should have been detained in July and August 2018.

However, the Approved Mental Health Practitioner (AMHP) made detailed notes about decision-making and discussions with the family.

It is clear from the history that Mr D was able to mask his symptoms, nevertheless the actions of the AMHPs are reasoned and evidence-based, and in line with expected practice.

Finding 6 – Spectrum CIC

The prison health care records note that information about mental health assessment and treatment should be conveyed to Mr D's GP to support a referral to secondary mental health services. This was not done, and it is not clear why, however, there was no policy guidance about information sharing after prison release.

Finding 7 – Trust EIP

The care and support provided to Mr D and his family by Early Intervention in Psychosis pathway (EIP) and especially the Care Coordinator (CCO) was of a high standard. They sought to understand Mr D's mental illness and provide him with treatment in the least restrictive manner.

Finding 8 – Trust care and treatment: risk assessment

Sexually disinhibited behaviours were not well managed on the mixed sex ward and consideration should have been given to moving Mr D to a male ward.

Risk assessments and clear care plans were not used in the decision to grant Section 17 leave, or to agree the use of leave when he requested it.

The family was not sufficiently involved in managing risk during the use of leave.

Finding 9 – Trust care and treatment: PICU beds

The rationale behind the plan that agreed to transfer Mr D to a male Psychiatric Intensive Care Unit (PICU) bed was not adequately described in his clinical notes, and alternative admission options were not discussed.

Finding 10 – Sexuality

Opportunities to explore Mr D's expressions of sexuality and its importance in relation to his mental health were missed.

Finding 11 – Trust care and treatment NICE guidance

The care and treatment offered to Mr D from his first presentation was of a good standard, in line with expected policy and practice in EIP and NICE guidance.

The Care Coordinator (CCO) provided excellent continuity of care and communicated regularly with family members.

Finding 12 – Cygnet Health Care management

Mr D was discharged from Cygnet Health Care Maidstone without due regard to:

- Cygnet Health Care Discharge Policy
- Risk information and Multi-Agency and MARE agreements
- Legal expectations of Section 117 MHA
- Family perspective

Finding 13 – Trust care and treatment: medication

Mr D was not treated assertively with antipsychotic medication.

There was an absence of appropriate care plans to address his lack of compliance and refusal to consider depot medication**.**

Finding 14 – Trust care and treatment: substance misuse

Mr D's use of cannabis was long standing and endemic. He was not motivated to change his habits and stop using cannabis. Services signposted him to substance misuse services. They had conversations with him about his cannabis use and encouraged him to consider stopping.

This was within normal policy expectations.

However, there was a failure to explore his psychotic beliefs in any depth, and to follow through on the conditions expected of Mr D while on leave, including abstaining from cannabis.

Finding 15 – Trust risk assessment

Trust mental health services completed regular assessments/reviews of Mr D in line with the requirements of the Trust's Risk Policy.

The GRiST[8] tool is challenging for staff to complete and difficult to interpret. It is a stand-alone document, not included on the electronic record (RiO). GRiST is series of screens and is colour coded to identify the elements assessed at that review. Mr D's GRiST assessments are very detailed, and this can be a challenge to the reader, and a summary would have been helpful.

There is no section in the assessment that invites staff to consider the risks that a patient might pose to adult family members.

Trust services did not complete a thorough assessment of Mr D's risk to his family. The family told care professionals on many occasions about feeling threatened and intimidated by Mr D, and that they had concerns about the risk he presented to his grandparents.

Finding 16 – Multi-agency Risk Evaluation (MARE)

MARE structures were used appropriately to share multi-agency information about Mr D's risk.

The actions of the agencies were monitored by the Mentally Disordered Offenders Coordinator as expected.

MARE information was made available to Cygnet but not used to inform the risk assessment and discharge planning process.

Finding 17 – Cygnet Health Care risk assessment

The risk assessment and reviews completed by Bearsted Ward were incomplete and did not fully reflect the known risks associated with Mr D that could be found in the referral documents, the GRiST and the Multi-Agency Risk Evaluation (MARE).

There was a lack of professional curiosity about the risks identified in the information shared with the care team by Mr D's home Trust.

The care team failed to identify Mr D's inappropriate behaviour towards the female staff on the ward.

The care team failed to re-assess his risk to staff following the incident of aggression towards staff.

Finding 18 – Trust family involvement

Family education and interventions, as outlined in NICE guidance 'Psychosis and schizophrenia in adults: prevention and management' (2014), were not provided.

Trust services included Mr D's parents in the decisions about his care.

Information about the support available to carers was provided to his parents.

Dova Unit were responsive to the concerns that his parents raised about the information shared by the Mental Health Act (MHA) Tribunal. The Ward met with

[8] *GRiST is a web-based risk assessment tool. https://www.egrist.org/*

his family and took the time to explain that they were not responsible for breaching the family's confidentiality. The Ward told the family that any sharing of information would be risk assessed.

Risk management considerations were not applied to his family.

Finding 19 – Safeguarding 1

There is no evidence to support that safeguarding was considered in relation to the sexual safety of patients on the ward. There were at least three opportunities where safeguarding advice should have been sought or a safeguarding referral made.

The Trust policy with regard to cumulative risks was not followed and there is no evidence to show that any consultation with the Trust safeguarding team occurred.

Finding 20 – Safeguarding 2

There is no evidence to suggest that risk to grandparents had been considered, this is despite the clinical team being informed that grandparents felt "frightened" and "scared" of Mr D. While the grandparents may not have met the criteria for an adult safeguarding enquiry (Section 42 Care Act 2014), there should have been a consultation with the Trust's safeguarding team to discuss the risk and how to manage this risk. This should have been completed prior to recommencing leave.

There is no evidence that any possible risk to children was considered.

Finding 21 – Mental Health Act

The use of the MHA was not discussed in sufficient detail with the family.

Mr D's family were not made aware of the responsibilities of the 'Nearest Relative', the potential to be displaced, or the implications of agreeing to Section 17 leave conditions.

It was not made clear to them that information given in confidence could be disclosed by the Tribunal.

Finding 22 – Serious incident review

Neither the NHS Trust or the Cygnet internal investigation met expected standards.

Best practice would have been a joint review completed in a collaborative manner by both Cygnet Health Care and the Trust.

Finding 23 – Cygnet Health Care

Cygnet Health Care Maidstone did not have systems in place to ensure policies were followed.

Finding 24 – Inter-agency information sharing

The existing frameworks for information sharing and management of risk were utilised.

The local MAPPA/MARE Policy is overdue for review.

Safer Cumbria does not have a structure for the oversight of actions from domestic homicide reviews.

There is a lack of oversight of the quality of care in NHS PICU out-of-area treatment placements.

Finding 25 – Domestic abuse

The Trust did not give sufficient consideration to the potential risk to Mr M following the hostility that Mr D presented while an inpatient.

Finding 26 – Domestic abuse local strategy

There is a high-level strategy for community safety, which includes the approach to domestic abuse.

Within the strategy there is no mention of risk to parents from adult children.

Finding 27 – Parricide

The understanding of potential risk of harm to parents was not incorporated into risk assessments by the Trust.

Mental illness and adult child-to-parent violence should be incorporated into domestic abuse strategies.

Recommendation 1

NHS Morecambe Bay CCG must

- Ensure that General Practitioners are reminded to consider a referral for a carer's assessment when carer responsibilities are indicated.
- Ensure that General Practitioners add safety alerts to relevant patient notes where an individual is known or suspected to pose a risk to others.
- Explore whether there are systems available to assess the safety of family members and informal care providers who are supporting patients with mental health issues in the community and advise GP practices accordingly. Encourage GPs to audit against this recommendation.
- Work with providers and medicines management teams to develop a process by which the GP / Practice Pharmacist are notified of patients failing to collect prescriptions and communicate this effectively to relevant parties, particularly where a shared care agreement is in place.

Recommendation 2

Cumbria and Lancashire Rehabilitation Company must provide assurance that:

- Risk assessments are updated at expected intervals and communicated to other agencies.
- There is a policy that applies where the individual is open to multiple agencies, clarifying when information and risk assessments must be shared with the other agencies involved.

This should relate to the Probation Service from June 2021.

Recommendation 3

Prison health care providers must ensure that systems are in place to share secondary prison health care consultations and information with GPs on discharge or release.

Recommendation 4

The Trust must ensure that there is clear guidance to be followed for the care of patients who present as sexually disinhibited, which adheres to national guidance on same sex accommodation.

Recommendation 5

The Trust must ensure the use of Section 17 leave is supported by robust risk assessment and clear care plans that are agreed by the multidisciplinary team (MDT) and families as appropriate.

Recommendation 6

The Trust must demonstrate that referrals for Psychiatric Intensive Care Unit (PICU and/or out-of-area treatment include clinical assessment and recommendations.

Recommendation 7

The Trust must ensure that evidence-based treatment plans are in place, that are in line with NICE treatment guidance 'Psychosis and schizophrenia in adults: prevention and management' (2014).

Recommendation 8

Any changes to the risk assessment tools used by the Trust should be informed by current research and recommendations from independent bodies. Any newly developed tools should be based on current knowledge and informed by independent experts in risk assessment in mental health services. They should also be subject to independent evaluation by experts in risk assessment before they are implemented.

Recommendation 9

Cygnet Health Care must ensure that the risks identified by local services are clearly visible in any risk assessment completed by Bearsted Ward, and that when risks are identified they are recorded and mitigation plans developed.

Recommendation 10

The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment.

Recommendation 11

The Trust must ensure that it is recognised that supportive families may also be at risk of harm, and that comprehensive assessments and supportive plans are developed.

Recommendation 12

The Trust must seek assurance that safeguarding supervision is accessible and provided to staff within ward environments in accordance with NHS England Safeguarding Accountability and Assurance Framework 2019.

Recommendation 13

The Trust must seek assurance that the Trust Safeguarding Service is made aware of Trust incidents where there is harm caused to a service user to ensure appropriate safeguarding oversight.

Recommendation 14

Trust and Adult Social Care staff must consider how best to communicate information to Nearest Relatives, so they can be assured that the Nearest Relative clearly understands their role and rights under the Mental Health Act. Simplified versions of written materials are recommended, where they are not already in use.

Recommendation 15

NHS England should share learning identified with the First Tier Tribunal (Mental Health) regarding providing guidance to families about how any confidential information they share may be used.

Recommendation 16

The Trust must ensure that serious incident investigations are carried out at the appropriate levels, within expected timescales and that they provide evidence of action plan implementation.

Recommendation 17

Cygnet Health Care must ensure that serious incident investigations are carried out at the appropriate levels, within expected timescales and that they meet expected NHS England national standards.

Recommendation 18

Cygnet Health Care policies should clearly demonstrate the sign off and governance process.

Recommendation 19

Cygnet Health Care must demonstrate and provide assurance to commissioners that their admission, discharge and Care Programme Approach (CPA) policies are adhered to.

Recommendation 20

NHS England should gain assurance about the quality of private PICU provision following the principles of host commissioning arrangements. This is to ensure that the local CCG/ICS monitors and has quality oversight for providers in their locality. Quality issues should be raised via the quality system oversight groups.

Recommendation 21

Safer Cumbria and the local Community Safety Partnership should develop systems to ensure there is oversight of the implementation of action plans from domestic homicide reviews.

Recommendation 22

The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members.

Recommendation 23

Safer Cumbria must develop and implement a comprehensive domestic abuse action plan which includes the learning from this review.

Recommendation 24

The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy and procedures.

Recommendation 25

NHS England should share learning identified about parricide with the Home Office.

Recommendation 26

NHS England should share the learning with the First Tier Tribunal (Mental Health) about parricide and risk to family members, and how sensitive third-party information is managed.

3. Establishing the joint review

Decision-making

3.1 This Domestic Homicide Review (DHR) is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.[9] The independent investigation follows the NHS England Serious Incident Framework[10] (March 2015) and Department of Health guidance[11] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.

3.2 A DHR must, according to the Act, be a review of:

"the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by–

a) A person to whom he was related or with whom he was or had been in an intimate personal relationship, or

b) A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death."

3.3 A court case has established that Mr D took the life of Mr M, and Mr D was under the care of mental health services at the time of the homicide, therefore both criteria were met.

3.4 South Cumbria Community Safety Partnership (CSP) was notified of Mr M's death, and a stakeholder meeting was held on 10 July 2019. At this meeting, it was agreed that a joint review would be undertaken. At this point, it was believed there was no known history of domestic abuse, but that Mr D was known to mental health services. Agencies were asked to ensure that all records were secured in preparation for the production of a chronology and Individual Management Review (IMR).

3.5 The following organisations were present at the first meeting:

- Cumbria County Council/Community Safety Partnership
- Barrow Borough Council
- Cumbria Partnership NHS Foundation Trust (CPFT/now CNTW)
- NHS Morecambe Bay Clinical Commissioning Group (CCG)
- Cumbria Constabulary

[9] *Domestic Violence, Crime and Victims Act 2004.* http://www.legislation.gov.uk/ukpga/2004/28/section/9

[10] *NHS England Serious Incident Framework March 2015.* https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf

[11] *Department of Health Guidance ECHR Article 2: investigations into mental health incidents.* https://www.gov.uk/government/publications/echr-article-2-investigations-into-mental-health-incidents

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- NHS England.

3.6 The following six agencies were approached to scope the review, and chronology was prepared with the information known by the different agencies. At the time of the incident the Cumbria Partnership Trust provided mental health services in South Cumbria. In October 2019 mental health services were absorbed by two existing Trusts with a north/south split. The south portion of the Trust's mental health services were absorbed by Lancashire Care NHS Foundation Trust to create Lancashire and South Cumbria NHS Foundation Trust. This review refers to CPFT as the Trust with regard to the care and treatment provided to Mr D, and the associated findings. The recommendations made are for LCSFT to action as the current provider responsible for the services involved. There was no known domestic abuse agency involvement. Serious incident reports and IMRs were commissioned from:

- Cumbria Constabulary.
- Cumbria County Council /Adult Social Care.
- NHS Morecambe Bay Clinical Commissioning Group, covering GPs for both.
- Cygnet Health Care.
- Lancashire and South Cumbria NHS Foundation Trust.[12]
- Cumbria and Lancashire Community Rehabilitation Company (CRC).
- Abbey Road Surgery.

3.7 Other agencies provided chronologies and relevant information when requested. Where this material is used within the body of this report, it is attributed accordingly.

3.8 The meeting of the South Cumbria CSP on 10 July 2019 agreed that there should be one process only, and a joint review should be commissioned. This investigation will be referred to as the 'joint review', with NHS England taking the lead for commissioning and oversight.

3.9 Niche Health & Social Care Consulting (Niche) were appointed to carry out the joint review starting in October 2019. There were long delays in the provision of information from the mental health providers, and the joint review panel met for the first time in July 2020. Further meetings and discussions followed and continued up to December 2020. All panel members fully engaged in the process, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings, additional work was undertaken via email, telephone and face-to-face meetings.

[12] *Lancashire Care took over the provision of mental health services in South Cumbria in October 2019. Lancashire and South Cumbria NHS Foundation Trust (LSCFT) were asked by Cumbria Partnership Foundation Trust to undertake the serious incident investigation for them.*

3.10 The review was completed in February 2021.

3.11 The Guidance states that a decision to hold a DHR should be taken within one month of the homicide coming to the attention of the CSP and the review should be completed within a further six months.

3.12 It was not possible to complete the review within the six months set out within the Home Office Statutory Guidance for the following reasons:

- Delays in the production of clinical records, and of the Trust and Cygnet Health Care internal reports.
- Practical restrictions due to COVID-19.

3.13 The joint review was carried out by Niche, with Dr Carol Rooney, Associate Director, as the independent Chair. Carol has completed many independent mental health homicide investigations commissioned by NHS England, including a previous combined DHR. She has completed 'Advocacy After Fatal Domestic Abuse'[13] DHR Chair accredited training.

3.14 The Niche review panel consisted of:

Elizabeth Donovan Senior investigator	NHS report author
Dr Mark Potter Consultant psychiatrist	Mental health clinical expertise
Hannah Candee Domestic Homicide Review Manager, Standing Together Against Domestic Abuse	Domestic abuse expertise
Sharon Conlon Safeguarding lead	Safeguarding expertise
John Kelly Retired senior police officer	Police expertise

3.15 The Chair has not worked for any of the agencies involved in this review and has complete independence from the agencies involved. None of the panel members has directly line managed any members of staff that had contact with the victim or the perpetrator. Internal supervision and quality assurance were provided by Nick Moor, Partner, Niche.

Confidentiality

3.16 The findings of this review are confidential. Information is available only to participating officers and professionals and their line managers until the review has been approved by NHS England and the Home Office. Following approval, the report should be shared appropriately within and between organisations to disseminate the learning.

[13] *Advocacy After Domestic Abuse (AAFDA) is a charity providing advocacy, training, and support. https://aafda.org.uk/*

3.17 Information from records used in this review was examined in the public interest and under Section 115 of the Crime and Disorder Act 1998, which allows relevant authorities to share information where necessary and relevant for the purposes of the Act, namely the prevention of crime. In addition, Section 29 of the Data Protection Act 1998 enables information to be shared if it is necessary for the prevention or detection of crime, or the apprehension and prosecution of offenders.

3.18 Medical records were shared by NHS organisations under the relevant Caldicott Guardian[14] processes.

Family involvement

3.19 We wrote to the families shortly after the appointment of Niche introducing ourselves, setting out the purpose of the review and providing the draft terms of reference. Mr D's parents had been divorced for many years, but maintained contact with each other regarding the care of Mr D. Both lived nearby and saw Mr D regularly. Mr D also spent a lot of time with his maternal grandparents, and they looked after his dog while he was in hospital. The two families involved are represented by Mr M's brothers and Mr D's mother Mrs L. Information was shared about the various advocacy services available to the family.

3.20 We met Mr M's brothers on 11 December 2019, and Mrs L on 17 January 2020. All expressed their wish that Mr M be referred to by his first name throughout the report.

3.21 The family asked several questions which they wished to be answered, and these were incorporated into the terms of reference (see Appendix D family questions).

3.22 We kept in touch with both families by regular email.

3.23 We would like to thank the families for their engagement and the contribution they have made to this review. It has been invaluable and has helped significantly in our understanding of the families.

3.24 The families were provided with a copy of the report in June 2021, and we met to discuss the draft report and receive their feedback.

3.25 Mr M's brothers and Mr D's mother have each submitted a family statement about their experiences, located at the beginning of the report after the preface.

3.26 We met Mr D in February 2020 in his hospital placement and shared the report findings with him. We did not receive any direct feedback.

Terms of reference

[14] *A Caldicott Guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly. https://www.ukcgc.uk/*

3.27 The terms of reference are provided in full in Appendix A.

3.28 The overall purpose of the joint review is to:

- Identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from December 2018, when Mr D was last admitted to a mental health hospital, to June 2019, when the homicide occurred.

3.29 The joint review will:

- Consider care provided from the date of Mr D's first contact with mental health services, with a focus on the period from December 2018 to when the incident occurred in June 2019.
- Request IMRs by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.
- Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding where domestic abuse is a feature.
- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to guidance from the police as to any sub judice issues; and sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process and any other emerging issues.

Equality and diversity

3.30 Throughout this review process the panel has considered issues of equality, in particular the nine protected characteristics under the Equality Act 2010. Those relevant here are:

- Age
- Disability
- Religion or belief
- Sex
- Sexual orientation.

3.31 Age was considered a relevant characteristic. Recent research into domestic homicide of older people showed that fact that older people are more likely to be killed by their child than by a partner.[15]

[15] *Bows, H. (2018) Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK. British Journal of Social Work (2018) 0, 1–20*

3.32 The panel considered disability throughout, including Mr D's mental illness. As part of the terms of reference we have reviewed information with regard to Mr M's potential vulnerability. He was not an 'adult at risk' in the meaning given in the Care Act 2014,[16] (see safeguarding section) and his family did not regard him as vulnerable.

3.33 Sex always requires consideration. Research reveals gendered victimisation across both intimate partner and familial homicides, with females representing the majority of victims and males representing the majority of perpetrators.[17] In this case, both parties were male. The panel considered this to see if the sex of either father or son impacted on their help-seeking or on the responses they received.

3.34 In addition to the previously mentioned protected characteristics, the panel agreed that particular attention should be given to the fact this is a case of fatal adult child-to-parent violence. While there is no single definition of adult family violence (AFV), fatal AFV is generally accepted to involve a homicide between family members aged 16 years and older, including the killing of a sibling.[18] Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 59 involved the killing of parents, or parricide (almost 15% of all domestic homicides).[19]

3.35 Standing Together's 2020 review report[20] found, of the AFV cases analysed, in 64% of the cases the perpetrator had mental health issues, (compared to 44% of Interpersonal Homicide DHRs looked at) of this 64%, 56% were diagnosed with a psychotic disorder, and 40% under the care of mental health services at the time of the murder.

3.36 However, the annual numbers are too small for any statistical analysis to be made. There is no separate data that provides details of parents killed by adult children or that links parental homicide with a history of domestic abuse.

Structure of the report

3.37 Section 3 provides detail of the background of Mr M, and details of the chronology of contact as known to relevant agencies, with analysis against the relevant terms of reference.

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[16] *The Care Act 2014 describes responsibilities of local authorities in relation to assessing people's needs and their eligibility for publicly funded care and support. http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted*

[17] *In 2014/15 there were 50 male and 107 female domestic homicide victims (which includes intimate partner homicides and familial homicides) aged 16 and over. Home Office, Key Findings from Analysis of Domestic Homicide Reviews (December 2016), p.3.*

[18] *Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) case analysis. Available at: http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf.*

[19] *Domestic abuse in England and Wales: year ending March 2018. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwales/yearendingmarch2018#domestic-abuse-related-offences-specific-crime-types*

[20] *London Domestic Homicide Review (DHR) Case Analysis and Review of Local Authorities DHR Process. https://static1.squarespace.com/static/5ee0be2588f1e349401c832c/t/5f633ee1e0e0be6ec5b858a1/1600339696014/Standing+Together+London+DHR+Review+Report.pdf*

3.38 Section 4 provides detail of the background of Mr D and the chronology of contact as known to relevant agencies, with analysis against the relevant terms of reference.

3.39 Section 5 sets out a narrative chronology of Mr D's treatment by mental health services.

3.40 Section 6 examines the issues arising from the care and treatment provided to Mr D, including comment and analysis.

3.41 Section 7 reviews the Trust and Cygnet internal investigation reports and progress on the action plans.

3.42 Section 8 examines the issues under the detailed terms of reference for the DHR.

3.43 Section 9 sets out the lessons identified, and our overall conclusions and recommendations.

4. Background and agency involvement – Mr M

Introduction

4.1 Information about Mr M was gathered from his family and his GP notes. The agencies that submitted Individual Management Reviews (IMRs) are covered in a narrative commentary that includes analysis relevant to the terms of reference. IMR information was provided by NHS Morecambe Bay CCG and Cumbria Constabulary.

4.2 Mr M 's family have provided us with their perspective, which has given an insight into their experiences. We have been given a sense of Mr M's life and his importance to the family, as well as the family's experience of caring for Mr D.

Mr M

4.3 Mr M was 70 years old when he died. He was a self-employed taxi driver who was well known locally, although he liked to keep his own life private. He was one of four brothers, and the family were very close. Three of the brothers live locally in Barrow and socialised regularly. One brother lives in Southampton.

4.4 Mr D is the only child of his parents, and they divorced when he was young. Mr D's mother brought him up, but Mr M had regular contact with him. Mr M had no other children, and he did not have a partner at the time of his death.

4.5 Mr M had planned to move abroad but decided to stay in Barrow when Mr D's mental health deteriorated. In 2018 he arranged for Mr D to move into a house that he owned, and Mr M moved to a caravan park on the coast. Mr M paid the household bills and saw Mr D regularly.

4.6 Mr M kept a diary of key events and concerns about Mr D, and his brothers supplied us with copies of extracts from his diary.

4.7 Mr M recorded that he had attended a review meeting (undated) in the Dova Unit with Mr D's consultant psychiatrist, his Care Coordinator (CCO), his mother and two staff. At that time it was raised that Mr D was refusing medication and may have been using cannabis on the Unit.

4.8 In January 2019 Mr M recorded that Mr D was very hostile to him. Mr M had taken his dog to see him, and Mr D said he only wanted to see the dog and told Mr M to go. On 11 January Mr M called the consultant psychiatrist's secretary asking to discuss Mr D's care. The consultant psychiatrist phoned Mr M on 15 January and said there were a couple of aspects of Mr D's behaviour that were concerning, and they were planning to change his medication. A social worker also called Mr M as the 'Nearest Relative' under the Mental Health Act (MHA), asking if he would agree for Mr D's detention under Section 3. Mr M agreed but said "he (Mr D) won't be happy". Mr M called the following day and was told it would not be a good day to visit Mr D.

4.9 Mr M was unhappy that disclosures he and Mr D's mother had made to Dova Unit were shared with Mr D during the First-tier Tribunal[21] in March 2019. They had disclosed risk information and concerns about Mr D that they believed had been given in confidence.

4.10 In April 2019 Mr M noted in his diary that he was concerned that staff were telling Mr D that his family was stopping him from having leave. Mr M made a note stating he wanted to know why a solicitor had told Mr D what his family's concerns were. Mr M wrote in his diary "it's not on" about this.

4.11 On 5 May 2019 Mr M noted there needed to be a discussion if Mr D was to return to the house, and that although Mr D had improved there was "'a long way to go". Mr M wrote that he attended the Dova Unit for a review on 6 May 2019, and Mr D still had an underlying psychosis and would need medication. He wrote that Mr D was not happy, but he was cooperating with the plan to involve the rehabilitation team, he had not been aggressive, but drug use was still a problem.

4.12 Mr D's mother reported to us that Mr D attacked Mr M while he was in the Dova Unit at Barrow (the date is unclear). Mr D believed that his family was keeping him there. Mr D was appealing his Section and he believed that Mr M had shared information with the staff to support his continued detention. Mr M was his 'nearest relative' under the MHA. The clinical notes recorded that in January 2019 Mr M visited the Dova Unit. Mr D became agitated and aggressive, clearly blaming Mr M for his detention under the MHA. His father was asked to leave the ward because of his agitation, but there is no record of him attacking Mr M.

4.13 While Mr D was absent without leave (AWOL) in May 2019 the police placed a trace on his bank account. The police made Mr M aware Mr D may be in Blackpool 8/9 days later and Mr M went to Blackpool to look for him. Mr M found him in a bank (Mr D was dressed in women's clothing). Mr D was concerned when he saw Mr M, and Mr M noted in his diary that he said "you're Dad but you're not Dad. How did you find me? Did you put a trace on me?" Mr D went AWOL on 18 May 2019. The LSCFT clinical records (RiO) note that Mr D was picked up by the police on 25 May 2019.

4.14 Mr M's brothers told us that in June 2019 the three brothers in Barrow planned to go on holiday together for Mr M's 70th birthday. His brothers reported that when Mr M went online to book the holiday the price had increased which put him off, and he did not go. They tried to persuade him to go but they could not change his mind.

4.15 Although Mr D's parents had been divorced for many years, they worked as a team to try to provide the family support they wanted him to have.

[21] *First-tier Tribunals (Mental Health) are responsible for handling applications for the discharge of patients detained in psychiatric hospitals.* https://www.gov.uk/courts-tribunals/first-tier-tribunal-mental-health

GP practice/NHS Morecambe Bay CCG

4.16 Mr M had been registered at Risedale GP Surgery, Barrow since 1972. We were supplied with GP records only as far back as May 2000, as previous records could not be located.

4.17 The GP records dating to the year 2000 show infrequent contacts for medical issues. Mr M had a history of minor medical issues, not deemed relevant to this review.

4.18 The IMR submitted by NHS Morecambe Bay CCG summarises that there was no indication of concerns, red flags or key relevant events being highlighted to the GP. The CCG scrutinised Mr M's contacts with the surgery between 2017 and June 2019. Appointments attended were mainly medicals for taxi licencing purposes, scheduled chronic disease monitoring appointments and routine physical ailments appointments.

4.19 In the GP notes there is no mention of Mr M's personal or social life, and there do not appear to be any concerns noted. There is no record of any concerns about Mr D, who was registered at a different GP practice in Barrow.

Finding 1 – NHS Morecambe Bay CCG/GP

Mr M's GP dealt with physical health issues, e.g. taxi licence health checks, and there were no serious physical or mental health concerns.

The GP service was provided within normal expectations.

Other services

4.20 There were no other services involved in Mr M's life. Issues of family involvement, risk assessment and safeguarding are addressed later in the report.

5. Background and agency involvement – Mr D

Introduction

5.1 The agencies that submitted Individual Management Reviews (IMRs) are covered in a narrative commentary which includes analysis relevant to the terms of reference.

5.2 IMRs were provided by NHS Morecambe Bay CCG, Cumbria County Council Adult Social Care (ASC), Cumbria and Lancashire Community Rehabilitation Company,[22] and Cumbria Constabulary. Internal investigation reports were provided by Cygnet Health Care and Lancashire and South Cumbria NHS Foundation Trust (LSCFT). At the time of the incident mental health services were provided by Cumbria Partnership Foundation NHS Foundation Trust (CPFT). CPFT asked that the investigation be undertaken by Lancashire and South Cumbria NHS Foundation Trust (LSCFT). This section reviews the information in the individual IMRs, and the internal investigation reports are reviewed in detail at Section 7.

Mr D

5.3 Mr D was 28 years old at the time of the homicide. He was described by his mother as very bright; he was good at Maths and did well in GCSEs and A levels. He did not have any idea what he wanted to do after school and did not have any plans for the future. He was a bit of a 'loner', who liked his own company and did not have many friends.

5.4 Mr D was very close to his maternal grandmother and her partner, Ken, and he spent a lot of time with them growing up. When he was young, he could become fixated on things. Mr D started to use cannabis when he went to college at 16, though his mother did not think he used harder drugs e.g. cocaine. His mother thought that most of his friends were associated with his cannabis use.

5.5 His behaviour became more erratic from the age of 19. This included:

- Poor personal hygiene.
- Poor eating habits, not eating healthy food.
- Standing on the spot, staring, for long periods of time. There was a time when the police were called to a local park because he was doing this. He could stand still for so long that he would be incontinent of urine.
- Talking about aliens.
- Saying that aliens had taken people over; Mum looked like Mum but was not Mum.

[22] *Now Cumbria & Lancashire Community Rehabilitation Company. Community Rehabilitation Company (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales.* https://www.clcrc.co.uk/home.html

- Believing that his body was out of alignment and he would walk with a funny gait.
- Not drinking water.
- Believing that everyone was trying to kill him.
- Isolating himself.

5.6 Mr D's behaviour was described by his family as "off the charts" in 2008. He did not want to live with his mother and split his time between Mr M's home and his grandparents.

5.7 There were concerns about Mr D's mental health while he was in prison in 2013. An assessment did not identify a role for the mental health in-reach team.

5.8 In April 2017 he had been arrested running up and down the road with a knife, talking about aliens being among us and needing to kill them. While he was in prison the staff became worried about him because he was covering things in foil and talking about aliens. His mental health was assessed, and he was transferred to the prison health care unit for a period of time. Mr D refused visits from his family while he was in prison and hospital.

5.9 His mother believed that his release from prison in March 2018 was not managed well by prison health services and this resulted in him not being referred to local mental health services for support. He had been transferred from the prison to court and was released home directly from court, (details are described later in the report). A referral was not made by prison health care to the Barrow mental health team. His mother was concerned that information about his care under prison mental health services and the hospital was not shared with Barrow mental health services at this time.

5.10 The family had concerns about Mr D, but it was difficult to get him to go to see his GP. However, in June 2018 his mother persuaded him to attend a GP appointment on the pretext of a problem with his hip. His mother had had a conversation with the GP in advance of the appointment about her concerns and had arranged a longer appointment to give the GP time to explore his mental health issues. His mother's brother supported Mr D to attend this appointment and managed to get him to stay with the GP long enough for him to start to talk about some of his strange thoughts. Mr D could "hold things together" for short periods of time. He was referred to the local mental health team in June 2018.

5.11 In 2018 Mr M moved out of the house in Barrow and left Mr D living there but paid the bills for the property.

GP practice/ NHS Morecambe Bay CCG

5.12 Mr D was registered at Abbey Road Surgery, Barrow, from his birth in 1991 but the registration lapsed, possibly because he had not recently attended. He re-registered with Abbey Road Surgery in June 2018 after prompting from family.

5.13 There are records of childhood GP visits for tonsil issues and coughs, but no serious illnesses or concerns. He was admitted to hospital with a tonsil abscess in 2008, and was referred to an Ear, Nose and Throat surgeon, but he refused any surgical interventions.

5.14 In September 2008 (aged 17) he was admitted to A&E at Furness General Hospital, having been found unconscious after an assault and consuming alcohol. He was discharged with no follow-up. He was admitted again in October 2008 after being found collapsed in the street. There were no serious injuries and he was discharged with no follow-up. In June 2009 he attended A&E with a laceration to his hand which did not require any follow-up treatment.

5.15 In October 2010 (aged 19) he saw the GP and complained of sleeping difficulties. It was recorded that he was living with his grandparents, smoking a couple of cigarettes a day, and not using any alcohol. Mr D asked for help to sleep, and he was prescribed 5mg diazepam[23] to be taken at night and was given advice about healthy lifestyle and the addictive properties of medication.

5.16 Mr D experienced several bouts of a persistent cough. In November 2010 he attended the GP with a persistent cough. He admitted he was smoking cigarettes but denied using drugs. Advice was given and he asked for diazepam to help him to sleep, which was prescribed but it was noted it was not to be given again.

5.17 Mr D attended A&E at Furness General Hospital in February 2011, complaining of vomiting due to tonsillitis. He was discharged with no follow-up treatment. In May 2012 he attended A&E with a fractured thumb and was provided with a splint and given advice. There is no reference to how this fracture was caused, or whether it was explored.

5.18 In September 2013, his mother called the GP to say the whole family were concerned about Mr D's addiction to cannabis. The GP advised he could be referred to substance misuse services, but he would need to see the GP first.

5.19 In June 2015 Mr D attended A&E with a head laceration but did not wait for treatment.

5.20 In August 2016 he attended the GP surgery with swelling in his elbow and was diagnosed with bursitis. At this time, he was working as a gardener and was temporarily signed off as unfit. He was treated for this up to December 2016 when it finally resolved.,

5.21 Mr D had a productive cough in October 2016 and admitted smoking cannabis regularly. Advice was given about the risks of cannabis abuse. In March 2017 he was given antibiotics for a persistent productive cough.

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[23] *Diazepam belongs to a group of medicines called benzodiazepines, which are normally used to treat anxiety symptoms. https://www.nhs.uk/medicines/diazepam/*

5.22 In February 2018 the GP surgery received a request for details of Mr D's medication and mental and physical health from HMP Preston. Abbey Road Surgery supplied the information.

5.23 Mr D attended the GP surgery complaining of hip pain on 6 April 2018. He described thinking he had some sort of hip injury, but the GP described him as muddled and unclear in describing what was wrong. His hip was examined and nothing unusual was found, and he was advised to do careful exercise only.

5.24 Mr D attended the GP surgery on 21 May 2018 again complaining of ongoing hip pain. He said he might have injured it during weightlifting, and now walked in short steps to avoid further injury. He also said he could not look at TV or computer screens because they affected his eyes. He was provided with a medical certificate as unfit to work and referred for a hip X-ray. There was no discussion of his mental health in this consultation, although the GP noted that it was difficult to make sense of what he was saying.

5.25 An X-ray of both hips was arranged which showed no abnormality. He was referred for physiotherapy.

5.26 His mother was a patient at the same surgery, and on 4 June 2018 she contacted the surgery to express concerns that Mr D was mentally unwell. He was reported to be making irrational statements regarding god, angels, demons and aliens. He had been carrying a knife because of this and had been arrested, then released from prison without any mental health follow-up. His mother said he was living with his grandmother and the family was worried that he might become aggressive and harm someone. She said that he did not believe he was mentally unwell. His mother was advised that limited information could be shared with her due to confidentiality, but the GP would see him to try to explore the issues if he could attend.

5.27 Mr D attended on 4 June 2018 for an appointment with the GP, accompanied by his maternal uncle. He expressed thoughts as described by his mother, and he said he was not eating or drinking much for fear of being poisoned. He had visible sunburn to his face and stated that he had been looking at the sun for long periods in the mornings as he felt the natural light would help his eyes.

5.28 He agreed to have a mental health assessment although he did not believe he had a problem and complained of hip pain.

5.29 The GP referred him for a physiotherapy assessment, and by email to the Community Mental Health and Recovery Team (CMHART) team, which was provided at that time by Cumbria Partnership NHS Foundation Trust (CPFT).

5.30 The GP spoke to his mother by phone explaining they could not divulge information due to confidentiality but gave assurance that actions had been taken following the previous consultation, and advised her not to oppose or necessarily agree in conversation with Mr D.

5.31 On 7 June 2018 an assessment was carried out at his grandmother's house by the Access and Liaison Integration Service (ALIS) team, accompanied by his mother and uncle. It was noted he had no history of contact with mental health services, apart from having been seen by the 'In-Reach Team' on 27 January 2018 while in prison. He had been referred to Guild Lodge[24] but the referral was not accepted, and it was suggested that he remain in prison health care for further assessment at the time.

5.32 The plan from this assessment was that:

- ALIS would further assess symptomology and risks via their '72hr pathway'.
- An outpatient appointment would be arranged with the ALIS Psychiatrist and Early Intervention in Psychosis Team (EIT) from CMHART.
- He was asked to complete a PHQ-9[25]and a physical health pro-forma.
- ALIS would offer a carers assessment to mum and uncle.
- ALIS would make a further home visit.

5.33 The ALIS team shared information with the EIT, GP and Mr D following assessment.

5.34 The physiotherapist noted on 4 July 2018 that Mr D had changed his gait consciously because he felt he needed to re-align his muscle imbalances to all the blood flow in his legs. He said he believed if he did this for the next two years his symptoms would heal. On examination he had marked sunburn on his shoulders and had a stiff slow gait with restricted posture. It appeared this restriction was due to anxiety/avoidance. The physiotherapist noted they discussed Mr D's 'maladaptive ideas' regarding his hip and he encouraged increased physical activity. It was also noted that he had been referred to the EIT for psychological input, which was thought to be helpful with regard to his beliefs about his body.

5.35 On 12 July 2018 a copy of Multi-Agency Risk Evaluation (MARE)[26] minutes were received by the GP. A safety alert was added to the electronic record. In August 2018 the practice was asked by the mental health team to take responsibility for Mr D's medication prescription, which by then was for olanzapine.[27] The caller requested that Mr D be given weekly prescriptions that were dispatched automatically on the same day ('repeat dispensing') because he was unlikely to order these himself.

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[24] Guild Lodge is part of the secure forensic service provided by Lancashire & South Cumbria NHS Foundation Trust. https://www.lscft.nhs.uk/guild-lodge

[25] Patient Health Questionnaire (PHQ-9) is a patient questionnaire used to screen for severity of depression. https://patient.info/doctor/patient-health-questionnaire-phq-9

[26] Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy, January 2017.

[27] Olanzapine is an antipsychotic medication. https://www.nhs.uk/conditions/psychosis/treatment/

Finding 2 – NHS Morecambe Bay CCG/GP

The GP dealt with physical health issues as they arose when Mr D was younger, making specialist referrals as appropriate.

Information was provided to prison health care services when requested as expected.

The GP responded to family concerns about Mr D's mental health, making onward referrals to secondary mental health services, and maintaining confidentiality as expected.

The Multi-Agency Risk Evaluation (MARE) minutes were received and content about risk noted, the internal process for GP review was followed. A safety alert was added to his notes due to the potential risk to self and others. A copy of the MARE notes was filed.

There were no documented actions in relation to assessing any risks to family members, or to making a referral for a carer's assessment.

Prescribing of antipsychotic medication was taken on by the GP practice, without the support of a monitoring system to respond to compliance issues, which was not standard policy at the time for Primary Care.

Recommendation 1

NHS Morecambe Bay CCG must

- Ensure that General Practitioners are reminded to consider a referral for a carer's assessment when carer responsibilities are indicated.
- Ensure that General Practitioners add safety alerts to relevant patient notes where an individual is known or suspected to pose a risk to others.
- Explore whether there are systems available to assess the safety of family members and informal care providers who are supporting patients with mental health issues in the community and advise GP practices accordingly. Encourage GP's to audit against this recommendation.
- Work with providers and medicines management teams to develop a process by which the GP / Practice Pharmacist are notified of patients failing to collect prescriptions and communicate this effectively to relevant parties, particularly where a shared care agreement is in place.

Cumbria Constabulary

5.36 The police Individual Management Review (IMR) was prepared predominantly by examining the interactions between Mr D and Cumbria Constabulary, although some documentation examined pertains to Lancashire Constabulary when Mr D was reported missing on 18 May 2019.

5.37 The police IMR records that Mr D's first recorded contact with Cumbria Constabulary relates to an incident in September 2008, outside the scope of this review. He was found unresponsive, lying in the street in Barrow, and was taken to Furness General Hospital. It was found he had consumed too much alcohol, and no other substance. He told officers he had taken some alcohol from his grandparents' house and could not remember anything else.

5.38 A summary of involvement is provided below:

Date	Issue	Outcome
March 2009	Suspected of dealing in cannabis to children at school.	Surveillance only.
November 2009	Suspected of dealing in cannabis from home address.	
May 2010	Wounding with intent to cause grievous bodily harm and affray.	Remanded in custody, sentenced to 12 months in young offender institution (YOI).
November 2010	Assault on police officer after stop & search, supplying cannabis.	Remanded in custody, sentenced to 12 months in YOI for police assault, possession of controlled drugs and supplying controlled drugs.
February 2011	Went into a local shop with his face covered. He went behind the counter and pushed a lady over. He then took the money from the till before becoming involved in a struggle with the man who owned the shop.	Remanded in custody, sentenced to 30 months in YOI, HMP Lancaster Farms.
December 2011	Released on licence from YOI to reside at mother's address.	Licence expires August 2013, under probation supervision. Not to enter certain premises or approach certain individuals.

January 2012	Met the threshold for police ViSOR[28] registration for violent offending.	Flag attached to his police intelligence records.
March 2012	Noted to be visiting flat of a known drug dealer.	Added to his police intelligence records (ViSOR).
July 2012	Domestic violence incident with pregnant stepsister (aged19).	Interviewed voluntarily after alleged assault on stepsister. Admitted argument and tipping over a chest but denied it had hit her. Common assault recorded, but no further action by Crown Prosecution Service. The incident was said not to meet the threshold for information sharing with other agencies.
April 2013	Public protection alert, found with a known drug dealer with cannabis in possession.	Cannabis warning issued.
September 2013	Assault occasioning actual bodily harm (ABH). Approached a 26-year-old man who appeared to be under the influence of a of drug. Mr D repeatedly punched and kicked the man leaving him with a swollen left knee and bruised left eye. Mr D then walked away in the direction he had come from.	Attended Barrow Police Station and admitted the assault. Remanded in custody, sentenced to 100 days imprisonment in December 2013.
January 2014	Police public protection alert.	Released from HMP Haverigg, as sentence under a year.

[28] *In the United Kingdom, the Violent and Sex Offender Register (ViSOR) is a database of records of those required to register with the police under the Sexual Offences Act 2003 (the 2003 Act), those jailed for more than 12 months for violent offences, and those thought to be at risk of offending.* https://www.app.college.police.uk/app-content/major-investigation-and-public-protection/managing-sexual-offenders-and-violent-offenders/

February 2014	Public protection alert, found with a known drug dealer in possession of items linked to cannabis, and a large amount of cash, but no actual cannabis.	Cannabis warning issued.
April 2015	Acting suspiciously with another, sound of smashed glass.	Searched, nothing found, smashed wine bottles.
February 2016	Reports of people coming to the front door of his house, suspected drug dealing and noise, violent and intimidating to neighbours.	Contacted father who said he will speak to his son about visitors and noise.
March 2016	Neighbours complaining of loud noise at night and strong smell of cannabis.	Police attended, described Mr D as unpredictable and intimidating especially towards females (neighbour).
March 2016	Arrested for abusive and threatening behaviour, verbally abusing an off-duty police officer, and possession of cannabis.	Charged with threatening/abusive behaviour, possession of cannabis, dealt with at magistrates' court.
May 2016	Magistrates for above offences.	Convicted, fined £80, victim surcharge £20, forfeiture of drugs, costs £325, community order unpaid work 100 hours.
June 2016	Police intelligence: notified of return to home address.	Playing loud music late at night disturbing neighbours, to contact Environmental Health (EH).
August 2016	Police intelligence: continuing to play loud music at night disturbing neighbours.	Neighbour told police she is very frightened of him. Leaving music playing loudly then leaving the house. Currently an alert regarding ongoing issues, noise detection device to be fitted by Environmental Health (EH).

October 2016	Police intelligence: lots of callers to the house day and night, house smelling of cannabis.	
October 2016	Failed to comply with requirements of community order.	Summoned to Magistrates November 2016, order to continue.
September 2017	Complaint by neighbours and strong smell of cannabis from the house.	Visited by police, quiet and not smelling of cannabis, EH involved.
October 2017	Shoplifting, damage to property, possession of offensive weapon (large knife) in a public place, affray, battery, assault on a constable, ABH. Remanded in custody HMP Preston.	Imprisonment 43 weeks in total, 23 weeks consecutive, common assault 20 weeks consecutive (assault 4 weeks and possession 20 weeks concurrent).
March 2018	Released on licence 13 March 2018.	Probation supervision licence until 9 August 2018.
March 2018	Neighbour complained of him standing in doorway waiting for her then being verbally abusive.	Section 5 Public Order Act noted, arrested & given police bail. Discussed with mental health services, Mr D agreed to write an apology and a Community Resolution was agreed.
June 2018	Maternal Uncle presented at Barrow Police Station. Uncle believed Mr D a danger to his grandparents, with whom he was now living.	Police Communications Centre took oversight of the report and asked for the Safeguarding Hub to check with the Probation Service whether checks were made prior to Mr D's release to that address, what measures were in place regarding his mental health and when the next planned visit was scheduled. This enquiry gleaned that an assessment was already planned for 2pm the next day, 7 June 2018.

June 2018	Officers attended grandparents address, seen with mother and uncle.	Mother was concerned about his mental health. Mr D was understood to have been on a mental health unit while in prison but released without any forwarding care. Showed signs of mental health issues but no signs of violence. Uncle agreed to stay at the house until the mental health assessment the following day. Police submitted a vulnerable adult (VA) form. It was noted on the form that permission had not been obtained from Mr D directly as he was suffering mental health issues but via his grandparents. On 7 June 2018 the report was shared with ASC. The following response was noted: “This has been triaged by the duty mental health social worker and as no consent has been obtained and no identified care and support needs, we will not be accepting this referral. Appropriate actions appear to be in place by Furness General Hospital”.
July 2018	MARE meeting.	Mr D was deemed to have capacity. Police note he must be dealt with under mentally disordered offender protocols if brought into custody. Noted to have early psychosis and paranoid thoughts and listed overall as high-risk. A number of risk factors and persons who may be at risk were noted (which did not include Mr D’s father). Following the MARE meeting an application was made the same day to

		put a police STORM[29] alert at his grandparents' home address. Mr D lived at his grandparents address and had made reference to carrying a knife with him for protection. Officers were advised, should they attend the address, they needed to be aware Mr D might be in possession of a weapon, possibly a knife.
August 2018	Approved Mental Health Practitioner (AMHP)[30] requested police to assist with Section 135 Mental Health Act (MHA)[31] warrant. Mr D was having regular episodes of psychosis and threatening family and had assaulted police. MARE meeting noted.	Living with grandparents, possibly carrying a knife, not taking medication, risk increased. Police helped execute the warrant, transported to the Dova Unit, he was then regarded as in the care of staff and police input was no longer needed.
December 2018	Police were contacted by a Community Mental Health Nurse. Mr D had attended Duddon House for an assessment and been sectioned under Section 2 of the MHA. He was described as becoming violent.	He was in a conference room with his father who was trying unsuccessfully to calm him down. Staff had left him in there with his father. Police attended and it was noted at 9.02pm Mr D had been escorted to the Carleton Clinic (Hadrian Ward) in Carlisle in an ambulance.
January 2019	Allegation of rape in Carleton Clinic, Carlisle.	Victim stated she had been raped by two men on the ward. The allegation was closed as the victim had not

[29] When domestic abuse is reported, the details are recorded on an electronic database called STORM and given a specific domestic abuse code. STORM is the command and control system used in the force communication centre.

[30] AMHPs exercise functions under the Mental Health Act 1983. Those functions relate to decisions made about individuals with mental disorders, including the decision to apply for compulsory admission to hospital. https://www.hcpc-uk.org/standards/standards-relevant-to-education-and-training/amh-criteria/

[31] Section 135 MHA is a warrant to search for and remove patients where there is reasonable cause to suspect that a person believed to be suffering from mental disorder (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or (b) being unable to care for himself, is living alone in any such place. https://www.legislation.gov.uk/ukpga/1983/20/section/135/england/2010-01-01

		been supportive. It was noted staff believed the allegation to be false, and Mr D was under observation every 10 minutes at the time of the alleged incident.
January 2019	Assault on inpatient Carleton Clinic. Verbal argument then punched and grabbed victim by the throat, staff intervened. Left victim with reddening to the head.	Open investigation, not resolved, although the other patient was classed as the victim. No vulnerable adult report was submitted as both men were patients in the care of medical staff.
March 2019	Concerns to Dova Unit from Barrow resident as had seen Mr D in the street shouting about Jesus and God.	Advised to call the police if distressed by him. Mr D at this time was on six hours of free time and expected back at the unit at 9pm. Staff at the Dova Unit were arranging for Mr D's father to go to his address as they were looking for him to return early so he would be safe in their care.
March 2019	Cannabis found in his room in Dova Unit, refused to let staff search his rucksack.	Police attended, seized cannabis. Police noted that he has 'no capacity' and cannot be dealt with criminally.
March 2019	Mr D was the victim of a theft. Reported at Barrow Co-op that he dropped his wallet, and it was picked up by a woman and handed to another man.	When confronted the male suspect handed the wallet in minus the money. Identities confirmed but evidential issues so not pursued.
May 2019	Alleged rape of female in a park in Barrow.	On description and behavioural traits Mr D was initially put forward as a potential suspect. He was subsequently ruled out from having any involvement before being spoken to.

May 2019	Missing from the Dova Unit on Section 3. Mr D was on leave at his grandparents and had left. He was due back at 3pm and had not returned. Recorded by police as a high-risk missing person.	Seen in Lancashire, Blackpool and Morecambe, missing person investigation continued, and passed to Lancashire Police. Financial checks had shown that Mr D was withdrawing money from National Westminster banks in the Blackpool area. His father had been to the banks in the Blackpool and Morecambe area to inform them his son was missing. On 25 May 2019 while his father was at the National Westminster bank at Blackpool, Mr D turned up there. The police were contacted and attended arriving at 10.30am. Officers were advised to take Mr D to Blackpool Victoria Hospital. Nobody from Barrow-in-Furness attended until circa 9.30–10pm that evening. At 01.09am early hours of 26 May 2019 it was noted on the police log that Mr D was now on his way to Kent in a secure ambulance.
May 2019	MARE meeting.	In a Psychiatric Intensive Care Unit (PICU) in Kent, will be returning to Cumbria. The same actions were noted as per the last MARE meeting, as well as inputting his details to be dealt with under the mentally disordered offender protocol. Other police actions were to ensure local officers were aware of Mr D and his issues, consider STORM alerts at grandparents and his own address should Mr D move back there. Further action to ensure sharing of

		any information from the police intelligence system (Red Sigma) that identified any risk factors. There was a new action that police should be informed if Mr D were allowed escorted or unescorted home leave and a named officer noted.

5.39 The police IMR lists the actions taken in response to Mr D's offending behaviour in relation to suspected drug use and drug dealing. The harassment complaints from neighbours were addressed individually, and then by a Community Resolution in March 2018.

5.40 There is a record of one incident of alleged domestic violence in May 2012, which was investigated by the police and a file sent to the Crown Prosecution Service for review. It was noted that this was not shared with other agencies at the time as it did not meet criteria for information sharing.

5.41 In June 2018 Mr D's uncle presented his concerns to police that Mr D's grandparents may be at risk. The police action was to find out what mental health assessment was planned via the Safeguarding Hub and attend the grandparents' address to assess the situation. Mr D presented as upset and experiencing mental health issues, but no risks were apparent. Officers asked if his mental health assessment could be brought forward, but was advised it could not, as there were no obvious risk indicators. It was arranged that his uncle would stay there until the assessment took place the following day.

5.42 A VA form was submitted by police, but the referral was rejected by the Safeguarding Hub because it was noted he had not consented to the referral and no care and support needs were identified. The referral named Mr D as the 'adult at risk' not the grandparents.

5.43 Police attended the MARE meeting in July 2018. The referral to the MARE panel was made by the ALIS team after a number of concerns about his mental state and reports that he was carrying a knife. The family had raised concerns about his potential risks to others. Mr D disclosed that he was carrying a knife to protect himself, he also suggested a young member of the family was not herself, and he talked of looking at child pornography. His offending history and current presentation were of concern, and Mr D was refusing to take antipsychotic medication.

5.44 A multi-agency action plan was completed, and the police actions were to ensure that information was entered onto systems to ensure that Mr D was managed under the Cumbria Mentally Disordered Offenders County Protocol if arrested for any offence, and consider whether or not it was appropriate to put a STORM alert on Mr D's address and his grandparents address. These were all marked as completed.

5.45 The Dova Unit reported Mr D as missing to the police on 18 May 2019. He was recorded by police as a high-risk missing person, and media alerts were made. They were interested in speaking to him about a sexual assault that took place in a park near his home address the evening of the day he went AWOL. Enquiries continued over the next few days by Cumbria Police, but Mr D was not immediately located. On 24 May 2019 the investigation was passed to Lancashire Police as there was evidence to suggest Mr D was in their area.

5.46 There was a further MARE meeting called on 25 May 2019, again attended by the police. The actions for the police were repeated as above, although it was recognised that there may be an increased risk to family members. A further action for all was added: "If the subject poses a risk that revolves around domestic violence the police must consider referring the victim/s to the MARAC[32] process". The list of potential people at risk included family members: his parents, grandparents and a young member of the family. It was noted that Mr D "had been aggressive towards his family members when challenged about his behaviours. Family members were fearful of his reactions and had felt unable to say anything to him. Mr M also reported there were massive stresses on Mr D's grandparents who are both in their seventies and are fearful of Mr D's behaviour".

5.47 However, it was noted that he had been AWOL from the Dova Unit but had been found and then transferred under Section 3 MHA to a PICU in Kent. He was not expected to be discharged in the foreseeable future, therefore there were no actions for the police to take at the time.

5.48 There was a request by the Care Coordinator (CCO) for a STORM alert on Mr D's mother's address after the discharge notification but this did not take place. The officer concerned has left the force, and it has not been possible to examine this further.

Finding 3 – Cumbria Constabulary

The domestic incident involving Mr D and his stepsister in 2012 was investigated appropriately.

Following the Multi-Agency Risk Evaluation (MARE) meetings police systems police protocols were followed to show how Mr D should be treated if he came into custody.

Police responded in a timely and proportionate way to concerns expressed by his uncle in June 2018, regarding the potential risk to his grandparents.

Lancashire Constabulary have reviewed protocols for patients when detaining an individual who has been absent without leave (AWOL) from detention under the Mental Health Act (MHA) to include provisions for when the patient is missing from outside of the Lancashire area and is not to be taken directly back to the place they are reported missing from.

[32] *Multi agency risk assessment conference*

Cumbria and Lancashire Rehabilitation Company

5.49 Community Rehabilitation Companies (CRC) were developed after the changes in the Offender Rehabilitation Act (2014).[33] They are private sector suppliers of probation and prison-based rehabilitative services for offenders in England and Wales. CRCs supervise offenders who present a low or medium risk of harm, while the National Probation Service (NPS)[34] manages offenders who present higher risks.

5.50 The purpose of the CRC is to protect the public by delivering effective offender management and rehabilitation services to low and medium risk of serious harm offenders, who are serving community sentences or have been released from prison on licence.

5.51 Mr D has a history of involvement with probation services, having been subject to the following periods of supervision prior to the most recent involvement with Cumbria and Lancashire Rehabilitation Company (CLCRC).

Date	Issue	Outcome
16/06/2011 to 03/08/2013	Offences of robbery affray, assault of a PC and conspiracy to supply cannabis.	NPS supervision.
12/08/2016 to 04/01/2017	Offences of threatening behaviour and possession of cannabis.	NPS supervision.
13/3/2018 to 9/8/2018; then post sentence supervision to 13/03/2019	Offences of shop theft, assault by beating, possession of an offensive weapon in a public place, criminal damage and assault on police officer x3.	CRC supervision. Sentenced to 43 weeks in custody, but he was granted an immediate release from court due to the amount of time on remand and was therefore subject to a period of licence supervision. He was released on licence until 09/08/2018 and then a subsequent period of Post Sentence Supervision from 09/08/2018 until 13/03/2019.

[33] *Offender Rehabilitation Act 2014.* https://www.legislation.gov.uk/ukpga/2014/11/contents/enacted/data.html

[34] *Now called The Probation Service.*

5.52 The NPS would normally provide the court, if requested, with a Pre-Sentence Report detailing the circumstances of the offence, the possible causes and explanation for the offence, the risk of further offences occurring and the level of risk of harm posed by the defendant. In this case the Pre-Sentence Report was not completed, and Mr D was sentenced without a report. The reason for this is unclear, other than a note on the system that suggests no member of NPS staff was available at the time.

5.53 Mr D was sentenced to 43 weeks in custody, but due to the amount of time on remand he was granted an immediate release from court. He was therefore subject to a period of licence supervision. He was to be managed by probation services on licence until 9 August 2018 and then have a subsequent period of Post Sentence Supervision from 9 August 2018 until 13 March 2019. While on licence he could be recalled to prison to complete the sentence if probation had concerns about him.

5.54 An NPS assessment resulted in the allocation of his case to the CRC and he was instructed at court to attend the CRC office the same day, 13 March 2018. Mr D attended Barrow CRC office and was inducted onto his period of supervision. This meeting takes the form of an explanation of the terms and conditions of a period of licence supervision, the expectations of him, as well as what he can expect from the CRC. He signed the induction agreement and was issued with a reporting instruction for 16 March 2018.

5.55 When Mr D attended on the 16 March 2018, his case had yet to be allocated to a responsible probation officer, he was therefore seen briefly by the duty officer. Mr D did not report any issues or concerns and a further instruction to attend was issued for 22 March 2018. The case was allocated to the responsible probation officer later the same day. The allocation was based on an initial risk assessment that Mr D posed a medium risk of serious harm to the public and staff (specifically police officers), it was also highlighted that one of the offences included possession of a weapon. The CRC case recording system was updated with flags to reflect the level of risk and the fact he was known to have committed an offence where a weapon was present (i.e. criminal damage by slashing car tyres with a bladed article).

5.56 Mr D attended on 22 March 2018 and was introduced to his allocated responsible probation officer. The probation officer used the session to build up a picture of Mr D, his risk and needs, with a view to creating an OASys assessment[35] (Offender Assessment System) and initial sentence plan.

5.57 Mr D met his officer on 27 March 2018 to complete a risk map; this is a piece of work which looks for the offender to articulate what they perceive to be their risky behaviour and how they can address this. Mr D identified his risky situation to be when he is forced to become defensive and suggested that by becoming more open and ‘at one’ with himself this would reduce this risk. The

[35] *Prison and probation services use a risk assessment tool called the ‘Offender Assessment System’. This is often called OASys. H M Prison order number 2205 (2005).*

OASys assessment and sentence plan was discussed with him, and he agreed to work on the following objectives:

- Impact of my behaviour on others (work to be completed on one-to-one basis by way of the 'Think Victim' workbook and other one-to-one worksheets).
- Education, training & employment (improve skills to find work by attending the programme via job centre for those released from prison).
- Thinking & behaviour – to generate alternative styles of thinking (work to be completed using one-to-one worksheets).

5.58 The above risk assessment and sentence plan was completed within the timescales of the CRC operating standards.

5.59 Mr D attended on a weekly basis over the next seven weeks, and one-to-one work was completed looking at the impact of his behaviour by completion of the 'Think Victim' workbook. This is intended to help him to evidence the likely impact for the victims of the index offences, the gains and losses of his offending and how he would manage the situation now. During this period one-to-one work was also completed on consequential thinking and as a result he agreed to work with Remedi Restorative Justice[36] services and wrote a letter of apology to the victim of the criminal damage.

5.60 Mr D advised his officer on 5 April 2018 that he had been arrested over an incident where he argued with his neighbour and was on police bail until 19 April 2018. This matter was eventually concluded in early May 2018 with a police community resolution.

5.61 The matter was discussed with the probation officer's line manager due to Mr D being subject to licence supervision, which states that there is potential for recall to custody for any further offending behaviour. Because no charge or conviction arose from this it was felt that recall to custody was not required as this did not demonstrate an increase in risk of serious harm that could not be managed within the community.

5.62 In May 2018 Mr D expressed a desire to seek employment and a referral was made to the CRC education, training & employment provider. However, when being made aware that information sharing protocols were in place Mr D chose to disengage from this service, citing that he did not want people knowing all about him.

5.63 When attending on 4 June 2018 his responsible officer noted that during the session Mr D's responses to questions raised concerns about his mental wellbeing with regard to conspiracy theories and paranoia. Substance misuse was discussed, and Mr D disclosed some cannabis use. He confirmed to his officer that he did not have a mental health diagnosis.

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[36] *Restorative Justice provides victims of crime and the offender responsible to communicate with the support of a trained practitioner. Remedi is an organisation that provides Restorative Justice (RJ) services in partnership with Youth Offending Teams, National Probation Service, CRCs, Police and Prisons.* http://www.remediuk.org/restorative-justice/

5.64 The responsible officer contacted the community mental health team on 14 June 2018 to advise of her involvement and concerns around Mr D's risk. They shared that a family member had disclosed Mr D was sleeping with a knife under his pillow and carried a weapon when out of the house. The community mental health staff reported this information to the police. The same day the responsible officer discussed the risk issues with her line manager. It was agreed that Mr D must be seen in a safe place and a risk flag around his mental wellbeing be added to the CRC case record system.

5.65 At his next appointment with his responsible officer on 25 June 2018 Mr D was challenged about the information they had of him carrying a knife, which he denied. He was advised of the potential consequences of such behaviour in terms of risk to others, risk to himself and the potential that he could be recalled to custody for breach of his licence. He was also reminded of the pattern of behaviour with knives, i.e. index offence. Mr D had said that he was a Jehovah's Witness, and the IMR noted that the suggestion Mr D was carrying a weapon should have been shared with the Jehovah's Witness safeguarding officer.

5.66 When seen on 9 July 2018 Mr D's compliance and engagement with the mental health team was discussed, he advised he was happy living with his grandparents and reported minimal cannabis use by way of cannabis oil. Discussions around the link between cannabis use and mental wellbeing were discussed but Mr D did not accept any link between the two.

5.67 The responsible officer made a home visit to see Mr D on 30 July 2018. The responsible officer had contacted the mental health team in advance of the visit for an update. During the visit Mr D advised that he wanted to move out of his grandparents' house to live at his father's house, where he would be living alone.

5.68 The responsible officer contacted the mental health team worker on 10 August 2018 for an update and was advised Mr D had been diagnosed with first episode psychosis and was receiving daily support and medication. When the responsible officer saw him on 20 August 2018 it was confirmed that he had moved into his father's property. During the period between 21 August 2018 to 5 November 2018 Mr D was seen a further three times, where the focus of the sessions was around his mental wellbeing and the support and medication received.

5.69 The responsible officer received a phone call from Mr D's father on 17 December 2018 to advise that Mr D was resident in the Carleton Clinic in Carlisle due to a deterioration in his mental wellbeing. The responsible officer contacted mental health services four times for updates during January 2019. They were told on 24 January 2019 that Mr D had been transferred to Dova Unit. On 25 February 2019 the responsible officer was asked to attend a multidisciplinary team (MDT) meeting the following day.

5.70 At the MDT meeting on 26 February 2019 it was agreed that release into the community was not appropriate. Mr D was advised that this would be the final

appointment with the responsible officer as his licence period of supervision would expire on 13 March 2019.

5.71 Positive practice was identified in the probation service IMR as follows:

- During the initial assessment and information gathering process (undertaken within 15 days of sentence) the responsible officer sought out information from the police regarding any outstanding matters in relation to criminal behaviour/risk to influence her risk assessment.
- The risk assessment and sentence plan objectives were appropriate for the nature of the offence and risk.
- The sequencing of work completed on a one-to-one basis and managed appropriately. Discussions with line manager at key points where there was potential for an increase in risk, and the decision not to recall Mr D (at 4.61 above) was reasonable.
- During one-to-one work the responsible officer drew Mr D back to his pattern of behaviour with regards to carrying a weapon and the potential consequences of such behaviour.
- Prior to carrying out a home visit the responsible officer checked with the community mental health team worker of any known risk issues.
- Responsible officer continued to seek updates/info from the mental health staff when Mr D was in hospital.

5.72 Areas requiring improvement were identified:

- Disclosure of a new offence was not verified with the police.
- Questioning of Mr D about a mental health diagnosis was not confirmed by way of contact with GP or community mental health team.
- Information to suggest a MARE meeting was to be set up was not followed up by the responsible officer.
- Disclosure of information suggesting Mr D may carry a weapon was not shared with the local Jehovah's Witness safeguarding officer.
- At the point of significant events, such as the confirmation of a mental health diagnosis and move of address, a review of risk assessment should have taken place.
- When advised by Mr D that his mental health was stable and he was taking medication as prescribed the responsible officer did not question this or confirm it with the mental health team.
- At point of admittance to hospital the responsible officer should have asked to be part of the MDT meeting process, to provide input in regard to risk issues and be part of the team/plan to support Mr D's wellbeing. There is no policy guidance about when to share information with other agencies involved.
- At point of termination of licence supervision, a formal written review of risk assessment should have taken place.

5.73 Mr D was not under CRC supervision at the time of the homicide in 2019, therefore a 'Serious Further Offence Investigation' was not indicated.

Finding 4 – Cumbria and Lancashire Rehabilitation Company

Community Rehabilitation Company (CRC) supervision was provided within timescales, but formal risk assessment reviews should have been conducted as circumstances changed, such as address change and admission to hospital.

There was a lack of cross-agency communication, and information about mental health care and medication should have been clarified with professionals from the mental health services.

Risk information should have been updated and shared with other agencies.

Recommendation 2

Cumbria and Lancashire Rehabilitation Company must provide assurance that:

- Risk assessments are updated at expected intervals and communicated to other agencies.
- There is a policy that applies where the individual is open to multiple agencies, clarifying when information and risk assessments must be shared with the other agencies involved.

This should relate to the Probation Service from June 2021

Cumbria County Council

5.74 There has been no historic contact with social care services. Mr D had no need of housing support because his family provided him with a house to live in and supported him with any self-care needs. Interactions with Cumbria County Council were largely in relation to assessments under the MHA.

5.75 Cumbria County Council Health and Care Services (H&CS) were contacted by the Early Intervention team (EIT) on 24 July 2018 to request a Mental Health Act Assessment (MHAA). A Section 135(1)[37] warrant was obtained via Barrow Magistrates. The warrant was executed with the police and the Trust's assessing psychiatrist. The AMHP noted that the warrant was not needed to transport him, because Mr D agreed to come for an assessment. Mr D was noted to be showing signs of psychosis, but tended to try to explain his beliefs, e.g. he was not drinking water to test out his theory of whether the government was spraying chemicals into the atmosphere.

[37] *Section 135 MHA is a warrant to search for and remove patients where there is reasonable cause to suspect that a person believed to be suffering from mental disorder (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control, in any place within the jurisdiction of the justice, or (b) being unable to care for himself, is living alone in any such place.* https://www.legislation.gov.uk/ukpga/1983/20/section/135/england/2010-01-01

5.76 Mr D was calm and compliant throughout the assessment and accepted the opinion of both psychiatrists[38] that he may be suffering from a psychotic episode, which they believed required a trial of medication. He agreed to attend an appointment to see the psychiatrist the following day, and work with the Home Treatment Team (HTT). He stated he would never want to be "locked up" in a hospital and if there were concerns in the future, he would prefer to discuss them in a planned appointment. The AMHP noted that the assessing team recognised that a community plan had been agreed. There was therefore no need for detention at that time. If Mr D did not engage with mental health services a further request for another MHAA could be made.

5.77 A further request was made by Early Intervention in Psychosis pathway (EIP) for a MHAA on 2 August 2018. The family reported that Mr D was agitated, self-isolating, screaming and that his grandparents were afraid of him. It was also reported that he had pushed his mother out of the room. Mr D had been brought into the Section 136 suite for the assessment by the police.

5.78 The impression from this assessment was that Mr D was experiencing a first episode of psychosis, but he did not meet the threshold for detention under the Act. It was also noted that he was willing to accept medication and engage with mental health services. Mr D was to be prescribed olanzapine after physical health checks had been completed. He was referred to the HTT for support with medication compliance.

5.79 It was noted by the AMHP that the legal criteria for detention were not met. A plan was agreed for Mr D to work with the HTT and attend assessment appointments. A mental health practitioner from the EIP team spoke to Mr D's father on 6 August 2018. He said that he did not agree with the outcome of the MHAA. He thought that Mr D should have been admitted to hospital and he said that he had told the AMHP this.

5.80 The AMHP discussed the assessment with Mr M (who was Mr D's 'Nearest Relative'[39] under the MHA) prior to seeing Mr D. Mr M said that he would not object to Mr D being detained but knew Mr D would not want that. The family were very worried about him, he was talking and shouting to himself when alone, and needed prompting to do basic self-care. Mr M said he did not believe that he would engage with services or take medication.

5.81 The AMHP discussed the decision not to detain Mr D with Mr M afterwards, and noted that Mr M was initially not pleased, stating he did not believe Mr D would attend the assessment appointment. The AMHP noted however that Mr M accepted that the community plan needed to be tried and tested given that Mr D stated he would engage.

[38] *A full MHAA requires the person to be seen and assessed by two doctors.*

[39] *Nearest relative under the MHA defines rights and responsibilities of relatives in relation to family members who are detained. https://www.legislation.gov.uk/ukpga/1983/20/section/26*

5.82 EIP staff made a referral on 21 August 2018 for an assessment of social care needs in line with the Care Act 2014.[40]

5.83 The assessment of social care needs was completed in October 2018. No needs were identified. Mr D did not identify any needs for support at the meeting so it was agreed the case be closed and re-referred should circumstances change.

5.84 A request for another MHAA was made by EIP in December 2018. The first attempt to locate Mr D was unsuccessful, and his mother was advised a further attempt would be made. The MHAA was carried out on 14 December 2018, with his mother and father both present. His parents reported that Mr D had initially seemed to improve and was taking medication. More recently he had lost a considerable amount of weight, was neglecting his personal care and hygiene, and was acting bizarrely. Neighbours had also expressed concerns that he was shouting and laughing to himself and praying in front of trees in the park. Both parents agreed that he needed a period of assessment, and EIP staff reported that he had declined requests to monitor his medication compliance, was not engaging with treatment and had refused any support from social care.

5.85 Mr D presented as unkempt, with matted hair, and was guarded in responses, with poor eye contact. He refused to accept any concerns raised, stating he was doing ok, and was "spiritual not psychotic". He had no recollection of being found in the park inappropriately dressed and claimed that urinating around the house was a form of cleansing.

5.86 The assessing team (which was the same as the earlier MHAA) was of the opinion that his mental health would continue to deteriorate if not adequately treated and that attempts to deliver treatment in the community had failed. The grounds for detention under Section 2 MHA were therefore met. He was detained under Section 2 MHA[41] on 14 December 2018 then formally admitted to the Hadrian Unit.[42]

5.87 Mr D's detention under Section 2 was due to expire on 10 January 2019. A request by his current psychiatrist to assess for detention under Section 3 MHA was made on 2 January 2019, and the MHAA was carried out over two meetings, on 3 and 7 January 2019. Mr D initially presented as preoccupied but was calm and relaxed at the second interview. He was able to acknowledge that his health and self-care had improved and agreed to stay informally at the unit and accept treatment. Neither of the two assessing psychiatrists recommended detention. The AMHP assessed Mr D's risk as low

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[40] *Care Act 2014 makes provision to reform the law relating to care and support for adults and the law relating to support for carers; to make provision about safeguarding adults from abuse or neglect; to make provision about care standards; to establish and make provision about Health Education England; to establish and make provision about the Health Research Authority; to make provision about integrating care and support with health services; and for connected purposes.* https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[41] *Section 2 MHA is admission to hospital for assessment and/or treatment for up to 28 days.* https://www.legislation.gov.uk/ukpga/1983/20/section/2

[42] *Hadrian Unit is an acute psychiatric ward for the whole of Cumbria based at the Carleton Clinic in Carlisle.* https://www.cntw.nhs.uk/services/hadrian/

at that time, but that it would increase if he started to use cannabis when he left hospital.

5.88 The family expressed their concerns to the Care Coordinator (CCO) that they did not think Mr D was responding to treatment and they were unhappy about the outcome from the MHAA. The CCO spoke to the ward twice on 9 January 2019. The plan was for Mr D to remain on the ward informally. There were no plans to discharge him and his prescribed medication was aripiprazole[43] 20mg.

5.89 The CCO also spoke to the Responsible Clinician[44] (RC) on 9 January 2019. The CCO did not agree with the RC's view that Mr D had the capacity to understand an informal admission. The RC advised ward staff to consider the use of Section 5(2) or 5(4)[45] MHA if Mr D declined to remain on the ward informally.

5.90 The Section 2 MHA was allowed to lapse, and Mr D remained on the ward.

5.91 In the early hours of 15 January 2019 Mr D wanted to go home. Following a conversation with the on-call doctor and ward staff he agreed to stay on the ward and speak to the RC.

5.92 A medical review with the RC concluded that he lacked the capacity to make decisions about his treatment options. The plan from the review was to request a further assessment under the MHA. If the outcome from the assessment was to detain Mr D under Section 3 MHA, his medication was to be changed.

5.93 An MHAA was completed on 15 January 2019 and he was detained under Section 3 MHA. It was felt that he was suffering from a mental disorder of a nature and degree that warranted detention in hospital for continued treatment, and for the safety of himself and others. He said he would stay informally but was assessed as not understanding that this would mean he would be expected to take medication and engage in treatment. Although he said he would continue to take medication he showed no understanding that it was required to treat his mental disorder.

5.94 On 5 February 2019, a referral was received from Dova Unit for a social care assessment of need. Mr D was still awaiting completion of necessary inpatient assessments, so the ward was advised to re-refer when these were completed.

5.95 On 12 June 2019, a request was received from his CCO for H&CS to undertake an assessment of social care needs. At this time Mr D was an inpatient detained under Section 3 MHA in Kent. H&CS were told that the

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[43] *Aripiprazole is an antipsychotic medication.* https://www.nhs.uk/conditions/psychosis/treatment/

[44] *Responsible Clinician (RC) is the Approved Clinician (AC) who has overall responsibility in terms of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) for a patient's case.* https://www.legislation.gov.uk/ukpga/1983/20/section/34

[45] *Section 5 (2&4) MHA relate to application to detain in respect of a patient already in hospital.* https://www.legislation.gov.uk/ukpga/1983/20/section/5

Section 3 MHA was due to expire on Friday 14 June 2019 and the local ward were going to allow this to lapse. It was noted by H&CS that "Cumbria health team do not agree with this decision and are attempting to liaise with inpatient team regards plans when formal detention period lapses".

5.96 H&CS received a call from the CCO on 13 June 2019. The CCO had spoken to Mr D's mother who advised that Mr D had been discharged and was making his way back to Barrow and had said he wished to move to Blackpool. It was agreed that the CCO would contact H&CS once they had been in contact with Mr D to agree an appropriate date to meet and re-assess care and support needs. A later email between the CCO and Team Manager/Social Worker at H&CS advised Mr D was back at his mother's. A joint assessment visit was agreed for the following week (2 July 2019) which did not take place because Mr D was by then in custody.

5.97 Decisions about detention under the MHA[46] are guided by five overarching principles:

- Least restrictive option and maximising independence
- Empowerment and involvement
- Respect and dignity
- Purpose and effectiveness
- Efficiency and equity.

5.98 It is clear from reviewing the notes that his family were very concerned and distressed by his presentation, particularly in July and August 2018. The notes record that the medical assessors had not made medical recommendations for detention, which means in their view he was not suffering from a mental illness to a nature or degree that required detention. The attending AMHP has made detailed notes about decision-making and discussions with the family, using the least restrictive principle to guide practice.

5.99 This was Mr D's first contact with secondary mental health services. He was able to converse calmly with assessors and had agreed to engage with mental health service staff and take medication. The risks to himself and others were felt to be reduced if he was engaging, and not using cannabis, and family were arranging for him to move out of his grandparents' house. The AMHP referred to the 'least restrictive principle' when recommending that the community plan should be tried in the first instance.

5.100 With hindsight, it is clear that Mr D was very able to 'mask' his symptoms and 'hold it together' while professionals were making an assessment. However, in our view the outcome of the assessments in July and August were reasonable based on the information available. Consultation with the 'Nearest Relative'

[46] *Mental Health Act 1983 Code of Practice (2015)* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

and wider family took place before and after the assessments, allowing time to hear their views.

5.101 Mr D was detained under Section 2 MHA in December 2018. Section 2 MHA is for assessment and/or treatment for up to 28 days. Mr D appealed, but the opinion of family and of the clinical team was that the Section should continue. A First-tier Tribunal upheld the Section 2 MHA, and it was noted that both parents believed this was the right decision.

5.102 The assessment for Section 3 MHA was carried out by the AMHP and another psychiatrist, who noted that he did not meet the clinical criteria for detention under the Act, and made a detailed entry explaining this.

5.103 On 16 January two medical recommendations were made for Section 3 MHA, and the Section 3 MHA application was made by the AMHP. The clinical aspects of this are discussed below in Section 5, mental health care analysis.

5.104 Once Mr D had been detained under Section 3 MHA he became entitled to Section 117[47] MHA aftercare. While this is a joint responsibility of the CCG and ASC, no social care assessment was completed to identify his needs following discharge. However, the last the last referral was made to ASC two days before discharge from Kent, and ASC made concerted efforts to follow up with the CCO.

5.105 There does not appear to have been any social care assessment completed during any of Mr D's hospital admissions. Referrals were made however the request to carry out assessment of social care needs was deferred as inpatient assessments were continuing and therefore this would not have been an optimal time to assess social care need. Formal discharge planning meetings should have taken place to confirm community care needs under Section 117 MHA.

Finding 5 – Cumbria County Council

Five Mental Health Act Assessments (MHAAs) were carried out between July 2018 and January 2019. Mr D was detained under Section 2 MHA in December 2018, and under Section 3 MHA in January 2019.

The family believe he should have been detained in July and August 2018.

However, the Approved Mental Health Practitioner (AMHP) made detailed notes about decision-making and discussions with the family.

It is clear from the history that Mr D was able to mask his symptoms, nevertheless the actions of the AMHPs are reasoned and evidence-based, and in line with expected practice.

[47] *After-care. This section applies to persons who are detained under section 3, or admitted to a hospital in pursuance of a hospital order made under section 37.* https://www.legislation.gov.uk/ukpga/1983/20/section/117

6. Mental health care and treatment

6.1 Mr D's first contact with mental health services was during a prison sentence in 2013.

6.2 We have summarised his care since 2013 and provided a narrative chronology of care from March 2018 onwards. We have analysed his care and treatment in detail against the terms of reference from March 2018 onwards in Section 6.

2013 to 2018

6.3 Mr D was seen for a mental health triage appointment while imprisoned in HMP Haverigg in December 2013. In this assessment he denied any mental health problems and the practitioner recorded that none were observed during the assessment. The plan was for no further input from the Mental Health In-Reach Team (MHIRT), but that Mr D knew how to access the team should he experience any problems with his mental health while in prison.

6.4 Mr D was detained on remand to HMP Preston between 12 October 2017 and 12 March 2018. He had been arrested for slashing the tyres of a car and threatening the owner with a knife. He was released following his appearance in court on 13 March 2018.

6.5 When Mr D was admitted to the prison in October 2017 the MHIRT[48] completed a review of the information available. This was because his mother had raised concerns about his mental health with the Criminal Justice Liaison and Diversion Team following his arrest. This review concluded that there was no role for the team at that time, but that Mr D could be referred to them if needed.

6.6 Mr D was referred to the health care team on 20 November 2017 because he had sustained a head injury. He said this was the result of a fall, but it was reported by prison officers that he had been the subject of an assault because of his bizarre behaviour. Mr D declined to have his head wound treated by the health care staff.

6.7 At the end of December 2017, prison staff contacted the MHIRT. They were concerned that Mr D was refusing to come out of his cell. The team reviewed his records and advised the prison staff to make a referral to the team if they had Mr D's consent for the referral. An initial assessment was completed by the MHIRT on 14 January 2018. Mr D refused to come out of his cell for the assessment, stating that he was afraid of being attacked. The mental health practitioner did not identify any mental health issues at this assessment.

6.8 At the request of prison staff Mr D was seen again by MHIRT on 27 January 2018. This was identified as a crisis call by the MHIRT practitioner. While on the surface Mr D presented as rational and lucid, he was displaying bizarre behaviours. He was not looking after his personal hygiene because of the

[48] *Mental health services commissioned to provide care and treatment in a prison setting - at the time by Spectrum CIC ltd*

chemicals in soap; he had wrapped his kettle in foil and plugged gaps around his sink with paper. The practitioner identified that Mr D appeared to be paranoid and was neglecting himself but there were no signs of him openly responding to auditory hallucinations. Mr D said that he had concerns, but he was not willing to discuss them with the practitioner. He said that he had not had contact with his local mental health services and would not give permission for them to be contacted.

6.9 The practitioner was unsure if Mr D had capacity or insight into his mental health at the time. The plan was for Mr D to be offered a psychiatric assessment. The practitioner and the prison staff considered that there were no risks in leaving Mr D in his cell at the time.

6.10 Following this assessment, the mental health practitioner gathered collateral information from Mr D's mother and the mental health services local to his home.

6.11 The visiting consultant psychiatrist completed a medical review on 30 January 2018. They concluded that Mr D's presentation suggested schizophrenia with gradual insidious onset. They identified that Mr D needed to be in hospital and a referral was made for an assessment by Guild Lodge.[49] He was also placed on the waiting list for transfer to the prison health care centre (H1).[50]

6.12 The MHIRT practitioner saw Mr D again on 6 February 2018 because of escalating concerns from the prison staff. Mr D's behaviour continued to be bizarre and he was now struggling to mask his thought processes, despite trying to present as lucid and rational. It was thought that it would be difficult to transfer him to H1 because he continued to refuse to come out of his cell. He was reviewed by the MHIRT in his cell on 13 February 2018, and no significant deterioration in his mental health was identified.

6.13 On 24 February 2018 prison staff raised further concerns about Mr D, he had made disclosures about historic access to child porn which was causing him some distress. Mr D was seen by the MHIRT as a result of these concerns and was transferred to H1.

6.14 While on H1 Mr D was reluctant to engage with the staff. It was reported that he could come across as superficially well, but his presentation and conversations could be bizarre. He would not use soap to wash and had concerns that the light from the television could harm his eyesight. He said he could sense "presences" and see "ghastly images" in rooms but if he said a prayer it was "ok", and he was observed responding to unseen stimuli. He continued to isolate himself.

[49] *Guild Lodge is part of the secure forensic service provided by Lancashire & South Cumbria NHS Foundation Trust. https://www.lscft.nhs.uk/guild-lodge*

[50] *The prison health care wing.*

6.15 Guild Lodge completed an assessment of Mr D on 28 February 2018 and concluded that he did not meet the criteria for transfer to hospital under the Mental Health Act. They advised that he should remain on H1 for observation.

6.16 The visiting consultant psychiatrist reviewed Mr D on 6 March 2018. They concluded that there was evidence of bizarre, paranoid preoccupations that pointed to possible schizophrenic process. The plan from this appointment was for Mr D to remain on H1. Should Mr D be acquitted at court there was a plan to pass information to his GP about his contact with the prison mental health services. If the outcome was that Mr D remained detained in prison the team was to consider prescribing aripiprazole.[51]

6.17 Mr D's medical notes were sent to HMP Forest Bank on 12 March 2018. We have not been able to establish if he was transferred there. He did not have any contact with health care services at HMP Forest Bank.

6.18 Mr D was released from court on 13 March 2018 because of the length of time he had spent on remand.

6.19 Mr D's case was discussed by the HMP Preston MHIRT on 13 March 2018, it was noted that he had been released following his court hearing. MHIRT did not share any information with his GP following his release.

March 2018 to June 2018

6.20 Mr D was released from prison and under licence until August 2018 and then under a Supervision Order until March 2019. He was required to meet with his probation officer regularly. Once he was under the care of mental health service there was communication between the probation officer and the team.

6.21 Mr D's home (owned by his father) needed some improvements, so he went to live with his maternal grandparents following his release from prison. Over the next couple of months his family became increasingly concerned about his behaviour. They reported that he was spending hours standing in a fixed position outside staring at the sky, that they had heard him screaming and shouting when alone in a room, that he was paranoid and was experiencing hallucinations relating to angels and aliens. He had changed his eating habits, lost weight and was preoccupied with concerns about his hip that had resulted in him walking with a strange gait.

6.22 Mr D was persuaded to attend an appointment with his GP on 4 June 2018 under the pretext of discussing the issues he was experiencing with his hip. He was accompanied to the appointment by his maternal uncle. His mother had spoken to the GP in advance of the appointment and explained the family concerns about his mental health. She requested that the GP allow sufficient time for the appointment so that Mr D would allow his guard to slip and the GP would have the opportunity of exploring Mr D's mental health issues with him.

[51] *Aripiprazole is an antipsychotic medication.* https://bnf.nice.org.uk/drug/aripiprazole.html

6.23 This prompted the GP to complete an extended appointment with Mr D, this additional time allowed them to explore the family concerns with Mr D. The GP made a referral to the Community Mental and Recovery Team (CMHART).

6.24 Mr D's mother contacted CMHART on 6 June 2018 to find out if they had received the referral. The lead for the psychosis pathway spoke to her. The referral had not been received from the GP at that time. They listened to Mr D's mother's concerns and assured her that once the referral was received it would be actioned and Mr D would be seen within 14 days. They also provided her with advice about what to do in the short term if her concerns escalated or she had any fears for the safety of the family. This included providing her with details of the Home Treatment Team (HTT) and advice to contact the police.

6.25 Mr D was accepted on the Early Intervention in Psychosis pathway (EIP) and was offered an appointment with the team for the 7 June 2018. This appointment was to take place at this maternal grandmother's home. However, that day a referral was received by the Access and Liaison Integration Service (ALIS)/HTT from the police. The police had been called by Mr D's maternal uncle because of Mr D's paranoid and suspicious behaviour. Mr D's appointment with the EIP did not take place, it is not clear why.

6.26 As part of the assessment ALIS completed a GRiST[52] risk assessment. This provided a comprehensive narrative of his problem risk, risk triggers and his persistent contextual factors. The plan from this was for Mr D to be accepted on the ALIS 72-hour pathway. This included support from ALIS and an appointment with the ALIS consultant. The opinion of the assessor was that Mr D needed to be referred to EIP for further assessment of his "potentially psychotic symptoms." However, despite Mr D's history of violence and aggression, his risk to others was determined to be low and his risk to dependents was very low. The assessment of his vulnerability was judged to be medium because of his suspicion of others and taking a knife into the community for protection.

6.27 Mr D was also seen for a medical review by the consultant psychiatrist from ALIS/HHT on 11 June 2018. It is unclear from the clinical notes if this was an assessment under the Mental Health Act (MHA). The outcome from the appointment was that Mr D did not meet the criteria for detention under the Act because he was willing to accept care and treatment from community mental health services. Mr D was not willing to accept intensive support in the community from ALIS/HTT, but he was willing to engage with EIP. Mr D was discharged by ALIS/HTT the following day, back to the care of the EIP.

6.28 EIP had allocated a care coordinator (CCO) to Mr D, and at the appointment on 11 June 2018 the CCO started a Comprehensive Assessment of Risk Mental State (CAARMS).[53] This was completed in an appointment with Mr D

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[52] GRiST is a web-based risk assessment tool, in use at the time by the Trust. https://www.egrist.org/

[53] Comprehensive Assessment of At Risk Mental States. Yung AR, Yuen HP, McGorry PD, et al. Mapping the onset of psychosis –the Comprehensive Assessment of At Risk Mental States (CAARMS). ANZJP. 2005;39:964-71.

on the 25 July 2018. This identified that Mr D started to experience changes in his mental health in 2014/15.

6.29 The CCO contacted his probation officer on 13 June 2018 to discuss reports that Mr D was sleeping with a knife under his pillow, and on one occasion had taken it out in the community for protection. The CCO told the probation officer that a Multi-Agency Risk Evaluation (MARE) referral had been made. The probation officer said that if Mr D were found carrying in knife in the community, he could be returned to prison under the conditions of his licence. The CCO also spoke to Mr D on the phone about the reports of him carrying a knife, which he denied. The CCO made an appointment to see Mr D on 19 June to continue the EIP assessment.

6.30 Mr D was accepted for assessment by EIP. He was given a welcome pack that included information about psychosis and the assessment tools that the team would utilise. In addition, he was given an assessment and engagement plan, including a crisis plan. Mr D gave consent for information to be shared with his father. He was reluctant to engage with mental health services and would not agree to weekly appointments with the team but agreed to meet the team fortnightly.

6.31 Mr D was supported by his father at the appointment on 19 June 2018. All appointments with Mr D were to be completed at the EIP team base because of the identified risks about Mr D carrying a knife. Staff were to undertake any home visits in pairs. Mr D's father supported him to attend all the planned appointments with EIP.

6.32 Mr D's assessment by EIP continued at appointments on 27 June 2018 and 10 July 2018. During these appointments it was noted that Mr D was unkempt. There were potential issues with a neighbour should he return to live at this previous address. Mr D was continuing to use cannabis and was not receptive to the idea that this was not helping with his paranoid thoughts.

6.33 On 24 July 2018 concerns were raised by Mr D's family about his behaviour. He was reported to be experiencing and responding to voices. He had been heard to scream "they're trying to section me" and "I'll kill them all." This resulted in EIP requesting an assessment under the MHA for Mr D. While the team was planning to complete this they reminded his family that if they had any concerns for their safety or for Mr D, they could contact the police.

6.34 EIP completed a GRiST risk assessment on 24 July 2018. This was a more concise assessment, and the plan was for EIP to complete a further assessment and arrange an appointment with the EIP consultant for a consolidation assessment and treatment options. There was also a plan for a Multi-Agency Risk Evaluation (MARE) meeting to assess his risk further.

6.35 The CCO contacted the Approved Mental Health Practitioner (AMHP) team and it was agreed that the assessment would need to be planned because it would require a Section 135 warrant. This meant that the assessment would probably not be completed until the following day. Mr D attended the planned EIP appointment with the CCO at the team base on 25 July 2018. He was supported by his father. He was unkempt, distracted and preoccupied but

there were no overt signs of psychosis. Mr D denied hallucinations and said that the issues with his family were because of their different lifestyle choices. They continued to complete the CAARMS[54] assessment. At that time Mr D was open to the idea of medication to keep himself calm but not as a treatment for psychosis.

6.36 Later in the day the AMHP informed the CCO that they had obtained the Section 135 warrant and would contact Mr D's parents to get their view of the need for a Mental Health Act Assessment (MHAA). Following a discussion with Mr D's parents the AMHP contacted the CCO and told them that Mr D's parents agreed that the MHA assessment should be postponed. If Mr D did not engage with mental health services a further request for an assessment under the Act could be made.

6.37 The CCO made a further request for an assessment under the MHA on 27 July 2018. The family were reporting that Mr D was agitated, self-isolating, screaming and that his grandparents were afraid of him. It was also reported that he had pushed his mother out of the room.

6.38 The EIP team obtained consent and cooperation from Mr D's parents before the assessment was completed on 2 August 2018. Mr D had been brought into the Section 136[55] suite for the assessment by the police.

6.39 The impression from this assessment was that Mr D was experiencing first episode psychosis, but he did not meet the threshold for detention under the Act because he was willing to accept medication and engage with mental health services. Mr D was to be prescribed olanzapine orodispersible[56] once an ECG and blood tests had been completed. He was referred to the HTT for support with medication compliance.

6.40 The mental health practitioner from the EIP team spoke to Mr D's father on 6 August 2018. He said that he did not agree with the outcome of the MHAA. He thought that Mr D should have been admitted to hospital and he said that he had told the AMHP this. He felt that Mr D was doing better since he had returned to live at his own address, although this move had caused some tensions in the family. Mr D was angry and upset because he thought that his family were not being supportive of him.

6.41 Mr D commenced taking 5mg olanzapine on the evening of 7 August 2018, having had an ECG and bloods completed. The HTT were to support this.

6.42 On 8 August 2018 EIP accepted Mr D for three years support and completed a care plan for him.

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[54] Comprehensive Assessment of At Risk Mental States. Yung AR, Yuen HP, McGorry PD, et al. Mapping the onset of psychosis –the Comprehensive Assessment of At Risk Mental States (CAARMS). ANZJP. 2005;39:964-71.

[55] Section 136 MHA Police powers to convey to a place of safety from a public place. (Removal etc of mentally disordered persons without a warrant). https://www.legislation.gov.uk/ukpga/1983/20/section/136

[56] A rapid-dispersing preparation to be placed in the mouth or alternatively to be dispersed in water or other suitable beverage for administration.

6.43 Between 7 and 20 August 2018 the HTT visited Mr D every day to monitor him taking his medication. His mother was present at each visit. He was not there on one occasion and the medication was left with his mother for her to give to him. There were occasions when the team thought that they had observed Mr D spitting out the medication, but he told them he had simply spat out some juice.

6.44 Mr D was reviewed by the EIP consultant psychiatrist on 10 August 2018 and his dose of olanzapine was increased to 10mg, which Mr D reluctantly accepted. The diagnosis given at this appointment was one of psychotic episode.

6.45 The HTT discussed Mr D in their multidisciplinary team (MDT) meeting on 20 August 2018 and it was agreed that they would monitor his medication on alternate days before discharging him back to the care of EIP. He was discharged back to the care of EIP on 29 August 2018. The CCO had referred Mr D to Adult Social Care (ASC) for a Care Act[57] assessment so that he could access support to ensure medication compliance. However, on 20 August 2018 Mr D declined a Care Act Assessment.

6.46 The EIP CCO continued to work with Mr D while he was under the care of the HTT. Mr D attended appointments with the CCO on 14 and 20 August 2018, in addition to the outpatient appointment on 10 August 2018.

6.47 EIP also worked with Mr D's parents. They had carer support sessions on 17 and 28 August, and a further one on 28 September 2018. In these sessions the team developed a comprehensive history for Mr D (completing a Premorbid Adjustment Scale[58]), provided his parents with information about psychosis and the support that was available to them, and gave them the opportunity to express their concerns. In the first session they told the team that they were unhappy with the outcome from the MHAA and were concerned about Mr D living alone and the risk of a neighbour taking out an injunction against Mr D. In the second session they explored issues around medication compliance and Mr D's poor money management skills because of his cannabis use. In the third session a safety plan was discussed with his parents, and the team reiterated advice about contacting the police if the family had any concerns about aggression from Mr D.

6.48 Mr D attended an appointment with the CCO on 29 August 2018, he was accompanied by his father. The CCO reminded Mr D that he needed to collect his medication from the pharmacy every week. Mr D was happy that the HTT were no longer visiting him and they discussed his mother monitoring him taking his medication.

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[57] *Under the Care Act 2014, local authorities must: carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care; focus the assessment on the person's needs and how they impact on their wellbeing, and the outcomes they want to achieve. Involve the person in the assessment and, where appropriate, their carer or someone else they nominate.*

[58] *The Premorbid Adjustment Scale (PAS) Structured Interview Schedule Description: The Cannon-Spoor Premorbid Adjustment Scale includes rating scales about 5 domains of functioning and a general section of items about quality of life.* https://faculty.biu.ac.il/~rabinowz/pas_interview_sections_version_22.pdf

6.49 EIP continued to see Mr D regularly through September. He was always accompanied to these meetings by his father. During the meetings the CCO was encouraging and supported Mr D to complete an Early Warning Signs Checklist. They also discussed medication compliance with Mr D.

6.50 Mr D's mother contacted EIP on 25 September 2018. She was concerned that Mr D's mental health was not improving and that he might not be taking his medication. She reported that he had been agitated and paranoid. While he was in the woods, she had heard him shouting and screaming. He had asked her "why her face looked like that." His mother was told a care coordination appointment was planned for the following day and reminded that she could get support from the ALIS/HTT if she had any concerns out of hours. Following the phone call EIP contacted the pharmacy who confirmed that Mr D had collected his medication on 20 September 2018.

6.51 When Mr D met his CCO the following day, they checked his compliance with medication. He told them that he had missed a "couple" of doses because he had fallen asleep. They advised Mr D to put an alarm on his phone to remind him to take his medication. At this time Mr D was not giving permission for information to be shared with his mother.

6.52 A Care Programme Approach (CPA) review was completed during the appointment with the CCO on 9 October 2018. The CCO noted that Mr D looked tired and was flat, giving minimal responses. At times during the appointment he looked confused and was easily distracted. He continued to use cannabis and he declined a referral to a substance misuse service. Mr D had lost some weight, and this was a recognised relapse indicator. Mr D had now agreed to a Care Act Assessment and the local authority had been allocated a social worker, who was to attend the next appointment with the CCO.

6.53 The CCO and the social worker from the local authority undertook a home visit on 16 October 2018, to complete a Care Act Assessment. Mr D's father was present during the appointment. Following the assessment Mr D declined support from the local authority. During the appointment Mr D said he did not believe he was experiencing psychosis, had been taking medication for six months, and asked to see the EIP doctor.

6.54 The CCO made an unplanned visit to Mr D's home on 2 November 2018. Mr D did not come to the door, although he was seen at the window. The CCO put a note through the door and then gave Mr D some time to come to the door but he did not. They provided feedback to Mr D's mother. The team was considering an MHAA, which was prompted by the family reports about his behaviour.

6.55 That day the CCO spoke to Mr D's father. He said that he had not been sharing information with the team because he did not want to go behind Mr D's back. He then told the CCO that Mr D was slow and doing bizarre things like putting the heating on full and leaving all the doors to the house open. His father asked why the treatment was not working and he was told that the team needed to complete an assessment. Furthermore, if Mr D had been

experiencing psychosis for a number of years, treatment might be difficult. He was told that the team would like to offer Mr D intensive treatment that would include medication, cognitive behavioural therapy, a Support Time and Recovery Worker and support from ASC. However, Mr D had declined this support and would only tolerate appointments once a fortnight with the CCO. They discussed the option of a hospital admission, but his father was reluctant to accept this.

6.56 Before a planned appointment on 12 November 2018 the CCO spoke to Mr D's mother. She told the CCO that Mr D was not doing well, he was staying in bed all day, not leaving his home and she did not believe that he was taking his medication. Mr D was able to rationalise his symptoms during the appointment. His father attended the appointment with him. Mr D was told that if he continued to refuse treatment the team might consider another MHAA. Mr D agreed to meet the team psychologist. He was reluctant to make another appointment to meet with the CCO; the CCO was to contact his father to arrange his next appointment.

6.57 Mr D met the EIP psychologist on 29 November 2018. A Cognitive Behavioural Therapy for psychosis (CBTp)[59] assessment was completed. The plan from this meeting was for the CCO to explore Mr D's symptoms with him using the Positive and Negative Syndrome Scale (PANSS).[60] The CCO was to arrange a medical review for Mr D to review the prescribed antipsychotic medication.

6.58 On 3 December 2018 Mr D was reported to be standing in a local park for a long time and this prompted a police welfare check.

6.59 On 6 December 2018 the CCO spoke to the CRC offender manager about the family concerns about Mr D and the possibility of an MHAA. Mr D's next planned appointment with the CCO was for the 14 December 2018.

6.60 On 12 December 2018 Mr D's father contacted the CCO and shared his concerns about Mr D. They agreed to do an unannounced visit to Mr D and to consider completing an MHAA. Later that day the CCO completed a home visit, accompanied by a colleague. Mr D was reluctant to allow them into his home and they returned to their car for a short time before he let them in. Mr D was wide-eyed, slow in movement, with a stiff body posture and he was talking in a higher pitch than usual. Following this visit the CCO requested an MHAA and informed bed management that he would need to be admitted.

6.61 The CCO completed a GRiST assessment. This identified his risk of harm to others or to property as medium, the focus of the risk was neighbours, people sharing living spaces and authority figures. His risk was determined to have

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[59] CBTp - Cognitive Behavioural Therapy for Psychosis (CBTp) is an evidence-based treatment approach shown to improve symptoms and functioning in patients with psychotic disorders. CBTp aims to enhance function despite difficult symptoms and experiences such as hallucinations, negative symptoms, thought disturbances, and delusions.

[60] The Positive and Negative Syndrome Scale (PANSS) is a medical scale used for measuring symptom severity of patients with schizophrenia. It was published in 1987 by Stanley Kay, Lewis Opler, and Abraham Fiszbein. It is widely used in the study of antipsychotic therapy. The scale is known as the "gold standard" that all assessments of psychotic behavioural disorders should follow.

increased recently because of his renewed use of cannabis. His risk of self-neglect and his vulnerability as medium. It also reported that he had experienced sun burn because of “sungazing.” This assessment rated his risk to dependents as none because he had no dependents. The plan from this assessment was to request an MHAA.

6.62 The MHAA was not completed on 12 December 2018 because Mr D would not return to his home and the duty AMHP believed a Section 135 warrant would be required. This view was not shared by the duty AMHP the following day. Following a discussion with Mr D’s father it was agreed that the MHAA would be completed at the EIP team base during the planned appointment on 14 December 2018.

6.63 Mr D’s father brought him to the EIP base for the appointment and an MHAA was completed. Mr D was behaving in a bizarre manner, expressing delusional ideas and his personal care was poor. The family view was that Mr D was not taking his medication and was using cannabis. Mr D told the assessing team that he was anxious and exhausted. The conclusion from the assessment was that Mr D met the criteria for detention under Section 2 MHA.

Hadrian Unit

6.64 Mr D was admitted to the Hadrian Unit under Section 2 MHA on 14 December 2018. The purpose of the detention was to complete an assessment of his mental health and review his treatment. His diagnosis was given as psychotic illness.

6.65 Following his admission to the ward a GRiST assessment was completed. This built on the risk assessment completed by the EIP CCO. The plan from this assessment included Mr D to be nursed on Level 2 observations, with no leave from the ward and for a formulation meeting to be held with the Responsible Clinician (RC).

6.66 A key feature of this admission was Mr D’s sexualised behaviours. He exhibited inappropriate behaviour towards women, both patients and staff. This included inappropriate staring and comments, being found on the female corridor and in patients’ bedrooms. On one occasion he was found in bed with a female patient, they were noted to have been fully clothed. There was a suspicion that the female patient and Mr D had taken part in oral sex, but they both denied it. Ward staff were concerned about the vulnerabilities of both individuals and to manage risks he was placed on enhanced observations when she was on the ward. He was also regularly observed by staff to be masturbating.

6.67 An initial assessment was completed on the ward on 15 December 2018 and a care plan and ward risk assessment were developed. During this meeting Mr D stated that he did not know why he was in hospital and he did not need to be there.

6.68 Throughout his detention to Hadrian Ward it is reported that Mr D smelt of cannabis and on one occasion ‘purple punch’, a cannabis derivative, was

found in his room. Mr D was offered advice about abstaining from cannabis use.

6.69 Throughout the admission Mr D was reported to be dishevelled in appearance. Ward staff reported Mr D talking in a Liverpool accent, responding to unseen stimuli on an almost daily basis, standing staring for periods of time, and appearing distracted. When he was challenged about these behaviours Mr D explained them saying that he was going through lyrics in his head and sometimes he would shout them out or that he was meditating.

6.70 Mr D's parents had regular contact with the ward during the admission and visited, despite it being a 4-hour round trip for them.

6.71 A formulation meeting/medical review was completed with Mr D on 18 December 2018. The plan from this meeting was to change his medication from olanzapine orodispersible to risperidone.[61] Mr D was provided with a leaflet to read about risperidone. A plan was later agreed to reduce the olanzapine orodispersible and to titrate him onto risperidone.

6.72 It was agreed that Mr D could have Section 17 MHA escorted leave from the ward, but this did not happen because the ward did not have available staff to support this.

6.73 On 20 December 2018 Mr D was accused of exposing himself to other patients on the ward. This was discussed with him in a one-to-one session. The ward was a mixed sex ward and the boundaries between the male and female sections of the ward were reinforced with him.

6.74 Mr D requested leave from the ward to go home for Christmas and his mother told the ward that the family were willing to support this.

6.75 Mr D was unsettled on the ward on 22 December 2018 because the ward could not support his agreed escorted leave. He was hostile with the staff when his request for additional food was refused. He was heard to raise his voice to his mother on the phone when she told him she would not be visiting that day.

6.76 A medical review was completed on 24 December 2018. Mr D's father attended this meeting. Mr D was refusing to take the prescribed risperidone but was happy to take olanzapine orodispersible or another medication. Following a discussion Mr D was prescribed aripiprazole[62] dispersible 10mg.

6.77 The meeting discussed Mr D having home leave. In a conversation with the RC his father said that Mr D had been aggressive in the past, but Mr D was less unwell now. He said that Mr D had not shown any aggression towards him or his mother. The family wanted Mr D home for Christmas and were

[61] *Risperidone is an atypical antipsychotic medication.* https://bnf.nice.org.uk/drug/risperidone.html

[62] *Aripiprazole is an atypical antipsychotic medication.* https://bnf.nice.org.uk/drug/aripiprazole.html

aware of risks. They were aware that they could contact the police if they had any concerns while Mr D was at home.

6.78 Prior to Mr D going on leave the ward updated his GRiST risk assessment. This safety plan included, “Family fully aware he is to be escorted at all times. Mr D says he will take his tablets and will not use cannabis”.

6.79 Mr D returned to the ward on 27 December 2018 accompanied by his mother and a medical review was completed. Mr D told the meeting that he did not believe he needed to be in hospital and that he did not want to take medication. Although he said he would take medication if the doctors told him to. He described the voices in his head as his own thoughts said out loud. His mother told the meeting that the leave had not gone well. She said that Mr D had been “hyper” and at one point during the leave had not slept for 24 hours. She was worried that he was unwell and that a further deterioration in his mental health would put others at risk.

6.80 A First-tier Tribunal held on 28 December 2018 upheld the Section 2 MHA.

6.81 The CCO spoke to both of Mr D’s parents following the Tribunal. His father reported that he regretted supporting the home leave and that while on leave he had been threatened by Mr D when he has refused to take Mr D to his home. He said that Mr D had been using cannabis while on leave. His mother reported that the leave had been difficult. Mr D had been chaotic, and she was not sure that he had been taking his prescribed medication.

6.82 A further medical review was completed on 31 December 2018 and Mr D agreed to an increase in the dose of aripiprazole to 15mg daily. The meeting also discussed prescribing medication by depot injection. Mr D was to be given Section 17 leave over the weekend if his family agreed. Mr D did not go on leave; it is unclear why.

6.83 The Section 2 MHA detention was due for review on 10 January 2019. On 2 January 2019, a request was made by the RC to Adult Social Care for an AMHP assessment to support this review.

6.84 Mr D was placed on Level 3 observations on 1 January 2019 when he was found in a female patient’s room. The ward reviewed his observation level on 4 January 2019. It was the opinion of the team that Mr D was finding Level 3 observations overstimulating. He had told staff that he enjoyed them. He had been running around the ward at 1am and making inappropriate comments to female staff. It was agreed that the female corridor door would be locked, and that Mr D’s observation level would be reduced to Level 2 (one in every 10 minutes). His care plan was updated on 5 January 2019.

6.85 His mother, grandmother and a friend visited on 6 January 2019. Mr D became agitated during their visit and was shouting that everyone was trying to keep him in hospital. His visitors had to leave the ward.

6.86 An MHAA completed on 7 January 2019 concluded that Mr D did not meet the criteria for further detention under the MHA. His detention under Section 2 MHA was due to expire on 10 January 2019, but they concluded that the RC

could discharge him from the section before this date if they thought it was appropriate. The AMHP assessed Mr D's risk as low at that time, but noted it would increase if he started to use cannabis when he left hospital.

6.87 On 7 January 2019, a female patient complained that Mr D was following her around the ward, and she wanted to report this to the police. The ward staff spoke to Mr D about this. He was unable to grasp why his behaviour was inappropriate. That day he also had an altercation with another patient and was inappropriate towards a female member of staff.

6.88 On 8 January 2019 Mr D's father told the CCO that the family did not think Mr D was responding to treatment and they were unhappy about the outcome from the MHAA. The CCO agreed to share the family concerns with the ward. When they spoke to the ward, they also raised concerns about Mr D's sexualised behaviours which had not been apparent in the community while he was being supported by EIP.

6.89 The CCO spoke to the ward twice on 9 January 2019. The plan was for Mr D to remain on the ward informally when the Section lapsed. There were no plans to discharge him and his prescribed medication was aripiprazole 20mg.

6.90 The CCO also spoke to the RC on 9 January 2019. The CCO noted that they did not agree with the RC's view that Mr D had the capacity to understand an informal admission. The plan was that the ward staff should consider the use of Section 5(2) or 5(4) if Mr D declined to remain on the ward informally.

6.91 His father contacted the ward on 10 January 2019. He was concerned about Mr D's bizarre behaviour. He thought that Mr D had got worse since his medication had been changed and questioned if he was taking it. He said that the family were concerned about Mr D being able to leave the hospital. Mr D's mother was not prepared to visit the ward because she did not want him to ask her to take him home. His father said that his mother was frightened of Mr D.

6.92 Mr D's GRiST assessment was revised on 10 January 2019. His 'risk to others' section did not identify an issue with him being overfamiliar with women, but it was documented in the safety plan.

6.93 The Section 2 MHA lapsed, and Mr D remained on the ward. Over the next few days Mr D became increasingly reclusive, spending most of his time in his room. In the early hours of 15 January 2019 Mr D wanted to go home. Following a conversation with the on-call doctor and ward staff he agreed to stay on the ward and speak to the RC.

6.94 A medical review was completed with Mr D later in the day. Medication options were discussed with Mr D. Little improvement had been seen in his mental health since he had been prescribed aripiprazole. However, Mr D would not agree to change medication or to a depot injection because of his beliefs as a Jehovah's Witness. The medical review concluded Mr D lacked the capacity to make decisions about his treatment. The plan from the review was to request a further assessment under the MHA. If the outcome from the

assessment was to detain Mr D under Section 3 MHA, his medication was to be changed to zuclopenthixol.[63]

6.95 An MHAA was completed later that day and Mr D was detained under Section 3. He told the assessing team that he thought he was experiencing a mild psychosis and was happy to take medication, but he did not believe he had a mental illness. He believed in "telepathy; when people manage people's gestures, mind and emotions". He talked about having his own ideology. He was willing to stay in hospital informally as he thought it was a good hostel that gave him the opportunity to socialise. Staff concluded that he had no insight into his behaviour. The conclusion was that his previous behaviours, including slashing tyres, had been driven by his paranoid thoughts. His risk was assessed as medium to low but could increase and his mental health deteriorate if he were to use cannabis.

6.96 Mr D was transferred to Dova Unit in Barrow on the afternoon of 16 January 2019. There is no documented reason for the transfer, staff at interview said that it was to move him closer to home, family and the community team.

6.97 Hadrian Unit was a four-hour round trip from his home. His parents were not informed of the transfer.

Dova Unit

6.98 Dova Unit[64] reviewed Mr D's GRiST assessment when he was admitted to the ward in January 2019. This assessment identified an incident when Mr D had another patient in a headlock and the police were called. It referred to the assault on Hadrian Ward when he assaulted a patient and had them by the throat. However, this did not result in his risk of harm to others being increased.

6.99 He was not happy about the transfer and told staff that he thought the Hadrian Unit was more age appropriate than Dova Unit. On the evening of the transfer he was heard screaming in his room and was hostile with staff who entered his room to check how he was.

6.100 Throughout his time on the ward, it was reported that Mr D was responding to unseen stimuli and neglected his personal hygiene. He was regularly observed masturbating in his room and standing in the garden for extended periods of time staring. We were told during the interviews for this investigation that Mr D would leave small bottles of his semen around his bedroom. He referred to this as "angel juice". He kept rotting food in his room, which posed a challenge to staff, and on one occasion his room was infested with ants.

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[63] *Zuclopenthixol is an antipsychotic medication.* https://bnf.nice.org.uk/drug/zuclopenthixol.html

[64] *Dova Unit is an acute mental health inpatient unit based on the Dane Garth site of Furness General Hospital. It provides hospital services for people with mental health needs (including people with learning disabilities who are suffering from mental health problems). It is now provided by Lancashire and South Cumbria NHS Foundation Trust.* https://www.lscft.nhs.uk/dova-unit

6.101 Mr D was offered opportunities for one-to-one with nursing staff while on Dova Unit, and he mainly engaged with these sessions. The ward completed weekly physical health checks, but Mr D would not allow them to take blood to complete blood tests.

6.102 A formulation meeting/medical review was held on 18 January 2019 with the Dova Unit RC. Mr D was given a working diagnosis of schizophrenia and was prescribed aripiprazole dispersible 20mg daily. Mr D acknowledged that he may have some signs of mental illness and a low dose of medication might help. He said that reports of him talking to himself were him rapping and practicing his film script. He denied masturbating in his room. The plan from the meeting was to increase the dose of aripiprazole dispersible and invite the CCO to the next medical review.

6.103 When his mother visited the ward on 19 January 2019, he did not want to see her. Furthermore, when his father visited the ward the following day, he was assertive and derogatory about him. He refused to see him saying, "he was the **** that got me sectioned." He also told the ward that they did not have his permission to share information with his father. The ward discussed this with his father and explained that Mr D's consent to share information may vary so the ward would discuss this with him from time to time.

6.104 The RC from Hadrian Unit provided the Dova Unit RC with information about the treatment plan for Mr D in a phone call on 22 January 2019. They said that Mr D appeared to be concordant with prescribed medication, but it did not appear to be having much effect. They said that the plan had been to prescribe a depot, flupentixol.[65]

6.105 Mr D's father visited the ward on 24 January 2019. Mr D became agitated and hostile, so his father was asked to leave the ward. As the day went on Mr D became increasingly agitated and aggressive and was considered a danger to staff and other patients. The staff had to restrain him using arm holds and lorazepam[66] 2mg was administered by injection.

6.106 Dova held an MDT review meeting on 29 January 2019 which was attended by the CCO. In this meeting Mr D requested a reduction in the dose of aripiprazole dispersible from 25mg to 10mg. It was agreed that the dose would be reduced to 15mg with an aim to start zuclopenthixol.

6.107 On 31 January 2019 Dova staff sent an email to the CCO. The ward staff were not comfortable supporting leave from the ward because Mr D was behaving inappropriately towards female staff. They were requesting EIP support Mr D's leave from the ward. The CCO advised them to discuss their concerns with the RC, and that if the ward were not comfortable to support leave it would not be appropriate for EIP staff to support it. Once this had

[65] *Flupentixol, also known as flupentixol, is a typical antipsychotic medication, as a long acting injection.* https://bnf.nice.org.uk/drug/flupentixol.html

[66] *Lorazepam is a benzodiazepine medication used to treat anxiety/agitation.* https://www.nhs.uk/medicines/lorazepam/

been discussed with the RC the leave prescription was updated and the CCO was to ask the Support Recovery Worker on the EIP team to support leave.

6.108 A medical review was completed on 5 February 2019. Mr D demonstrated that he had little understanding of his psychotic illness. He refuted nursing reports of responding to unseen stimuli, he denied poor personal hygiene and said he was washing. He did not know the staff were concerned about his disinhibited behaviour. The plan from this meeting was to reduce the aripiprazole to 5mg and to introduce zuclopenthixol 5mg. It was also agreed that he could have a trial of two hours unescorted leave. Mr D was advised to avoid illicit substances.

6.109 In February Mr D was initially given a trial period of two hours unescorted leave from the ward. This was revised to two hours escorted and two hours unescorted on 7 February 2019. On 7 and 8 February 2019 he returned to the ward smelling of cannabis. He was not given leave on 9 February at the request of his mother, due to failing to return to the ward on time and his behaviour at his grandmothers the previous day, when he had “kicked off” *(sic)*. On 8 February he locked himself in an outhouse and was chanting. The family were going to call the police, but they managed to persuade him to come out.

6.110 The ward informed his mother that Mr D was unhappy not to be given leave and to expect a phone call from him. He phoned his grandmother and she told him she was worried about him “kicking off” in her garden. He was not happy with this, told her she did not love him and asked to speak to his grandfather. His grandfather agreed to the leave, but ward staff did not agree.

6.111 This was discussed at his medical review on 12 February 2019 and two hours escorted leave was agreed. Mr D asked this be reviewed at the end of the week and that he be given more time off the ward. The leave was agreed on the condition that he did not spend long periods of time at his grandparent’s house. By the 16 February 2019 the notes indicate that his leave had been extended to three hours.

6.112 There was a Manager’s Hearing[67] on 19 February 2019 and Mr D’s detention under Section 3 MHA was upheld, and a Tribunal was planned for 10 April 2019.

6.113 The CCO contacted Dova Unit on 21 February 2019. They were concerned that there had been no improvement in Mr D’s mental health during his admission. They told the ward that an improvement had been seen when Mr D’s medication was being monitored by HTT. They shared the family’s concerns about Mr D’s behaviour when he was on leave from the ward, e.g. spending long periods of time in the garden praying.

6.114 A ward round was held on 26 February 2019. This was attended by the CCO, the Probation Officer and Mr D. It was reported that his relationship with his parents had improved. Mr D denied putting pressure on them or getting angry

[67] *Hospital managers have the authority to detain patients under the Act. MHA Code of Practice 2015*

with them and tried to rationalise his behaviours. He denied hallucinations and said he was rapping when staff thought he was talking to himself.

6.115 By 27 February 2019 he was allowed five hours escorted leave from the ward but continued to press for more. He returned from leave smelling strongly of cannabis, but nothing was found when his belongings were searched. He utilised this leave without incident until 5 March 2019 when there were reports from neighbours about noise at his home address.

6.116 This was explored in the ward round on 7 March 2019. There were concerns about Mr D's vulnerability when in the community. His leave was reduced to four hours escorted leave daily.

6.117 His father joined the ward round on 12 March 2019. Leave was discussed and it was agreed that Mr D would be allowed six hours unescorted leave daily from the following Monday. However, the Section 17 form completed the following day identified five hours escorted leave daily. This could be with either staff from the ward or his family. Mr D was supported to utilise his leave by his father, but he would often return to the ward smelling of cannabis and twice he was found with small amounts of cannabis.

6.118 When his father returned him to the ward on 21 March 2019, he told the staff he was concerned that Mr D was not taking his prescribed medication. He was also concerned that his mental health was not getting any better. He said that when on leave Mr D was spending long periods of time standing outside. The following day he was returned to the ward by his mother following a period of leave. Mr D said that he and his father argue "at times like that" but it was not serious.

6.119 In the ward round on 22 March 2019 the option of stopping leave to reduce Mr D's access to cannabis was discussed. The RC noted that this could risk an increase in his aggression and agitation, which could lead to him needing a Psychiatric Intensive Care Unit (PICU) bed. It was noted that a cannabis free period on Hadrian Unit had resulted in him spitting out his medication.

6.120 The ward round discussed his possible non-compliance with medication, but he disputed this. He suggested that he could have built up a resistance to olanzapine. He thought that the medication was "levelling him out". He refused a depot because of his religious beliefs. He denied cannabis use despite strong evidence that he was using it. He denied being paranoid, but he was still talking to himself. He explained that he was "narrating his film". He thought people were concerned because they did not know what was going on in his mind.

6.121 The plan from this ward round was for Mr D to remain on the ward until support was in place for him in the community. A referral was to be made to the local authority for reablement. If he was willing to remain on the ward until this was in place, he was to become an informal patient on the Friday. However, if it looked like Mr D would discharge himself against medical advice the decision to review and rescind the section would be left until the RC returned from leave at the end of the first week in April 2019. The meeting also discussed the need for a MARE referral.

6.122 A Section 17 leave form was completed following the ward round and it identified that Mr D was to be allowed eight hours unescorted leave from the ward, to return to the ward by 8.30pm. When his father came to the ward to take Mr D on leave, he went to check the changes with the staff. At interview it was acknowledged that there had been some inconsistency, with some staff more likely to approve leave than others.

6.123 On 23 March 2019, his father contacted the ward with concerns about how the leave had gone. His mother had had to return Mr D to the ward. He had sat in his grandfather's car until the battery ran down. His father had found medication in his car that he thought was Mr D's. The family felt unable to challenge Mr D because he could become violent and aggressive. His grandparents were afraid of him. The ward manager arranged for Mr D's father to speak to the RC. When he spoke to the RC on 25 March 2019 his father repeated these concerns and told the RC that Mr D was behaving bizarrely around a young member of the family, he was fixated on her. He also said that there were concerns about him fondling his dog inappropriately. Following this phone call the RC suspended Mr D's leave.

6.124 Mr D was reviewed by the RC on 26 March 2019. Leave was to be restricted to two hours leave supported by staff. There is no evidence available that Mr D accessed leave between 26 March 2019 and the ward round on 9 April 2019. In this ward round Mr D demanded that he be given leave. This was denied and was to be reviewed following the MHA Tribunal. Mr D was aggressive towards the ward staff on two occasions on 9 April 2019 when he was told that he would have to wait for juice and water.

6.125 Mr D's father spoke to the CCO on 9 April 2019. He remained concerned that there was no improvement in Mr D's mental health. He was frustrated with the ward. He said that he had reported that Mr D was not taking his medication.

6.126 At the ward round the following day it was suggested that the dose of zuclopenthixol be increased to the maximum dose of 40mg

6.127 On 10 April 2019 the Tribunal upheld Mr D's detention under Section 3 MHA. During the Tribunal some of the information that the family had shared in confidence with mental health professionals was shared with Mr D. The decision to share this information was made by the Tribunal Panel. Mr D's family were very angry about this disclosure. His father thought that this would put further pressure on strained family relationships and could put them at risk of harm from Mr D when he was unwell. His mother was concerned that his leave might be reinstated.

6.128 Mr D was given leave to be supported by a worker from the CMHT on 12 April 2019. He did not understand why leave with his family had been suspended. He hypothesised about his actions with the dog and the inappropriate behaviour with the young family member. He suggested that inappropriate behaviour around her was him swearing and that he had grabbed the dog's genitals during "rough play".

6.129 On 14 April 2019 the staff observed inappropriate behaviour between Mr D and a female patient. Mr D was asked to go to his room by the staff. The

increasing number of concerns about risk, including his inappropriate behaviour towards women, resulted in a MARE referral being made by the CCO.

6.130 The CCO attended the ward round on the 16 April 2019. It was reported that Mr D's mother had said she would leave the decision up to the ward team, but she did not think that he had recovered from his psychotic illness and she did not think that he was compliant with his medication. He was to be allowed two hours leave, escorted by either his mother or EIP. Medication options were discussed. Mr D did not want to be prescribed olanzapine because of the lethargy he had experienced when it was prescribed in the past. He cited religious reasons as his objection to a depot and would not accept clozapine[68] because of the monitoring blood tests required. However, he did accept a change to olanzapine and there was a plan for titration. The meeting also discussed Mr D transferring to a rehabilitation ward.

6.131 Overnight on 17 April 2019 Mr D was reported to be shouting in his room, responding to stimuli and openly masturbating in his room. On 18 April the RC had contacted his mother to discuss if she would be happy for Mr D to go out on leave for two hours escorted. She advised that she would be happy to support this however she was going away a couple of days and this would need supporting by the rest of the family.

6.132 On 19 April 2019 his mother supported leave from the ward. She reported that he was acting bizarrely, shouting in the garden and was aggressive, hostile and confrontational with the family and the public. Leave was suspended because of her concerns.

6.133 A mental state assessment was completed on 20 April 2019. Mr D was unkempt and his personal care was poor. He was displaying bizarre behaviour on and off the ward. He had no insight into this mental health and psychosis. His mood was fluctuating, and he was responding to unseen stimuli.

6.134 Over the following few days Mr D continued to act bizarrely and respond to unseen stimuli. On 22 April 2019 there was an incident with another patient. The patient took Mr D's orange juice and Mr D responded by shouting in the patients face. This occurred twice although Mr D did not respond the second time.

6.135 The RC met Mr D's parents, grandparents and CCO on 26 April 2019 to explore the concerns the family had about Mr D. The family said that the Ward sharing the family's concerns about Mr D with him was putting them at risk. Mr D had been hostile and aggressive towards them since the disclosures made during the MHA Tribunal. They were told that the decision to share information with Mr D was risk dependent. The Ward had not shared information with Mr D, this had been the decision of the Tribunal.

[68] *Clozapine is an atypical antipsychotic medication.* https://bnf.nice.org.uk/drug/clozapine.html

6.136 Mr D's mother described him responding to voices, shouting, "we will have to kill them." She said that Mr D believed that his "snot" (sic) had healing powers and he was not showering because he believed that the water contained harmful elements. His parents were concerned that Mr D was not taking his medication. His father reported finding tablets he believed to be Mr D's in his car. They were told that there were changes in staff and not all staff might be aware of the need to observe Mr D taking his medication. It was agreed that his medication chart would be updated to include the instruction for staff to observe Mr D taking his medication and to be vigilant, as he might try to hide the medication rather than take it.

6.137 There was a discussion about medication options. The family were told that the Ward had to respect Mr D's identified beliefs as a Jehovah's Witness when exploring medication options with him. This was Mr D's self-identified religion. He had not been brought up in the faith and there is no evidence he had attended any Church or services. Mr D declined to accept blood tests or injection on the grounds that it was against his beliefs. EIP staff did explain to Mr D that Jehovah's Witnesses would not accept blood transfusions or blood products but this did not alter his view about not allowing blood tests or injections on grounds of his religious beliefs. The staff believed that Mr D expressed this belief to legitimise his refusal of blood tests and a depot injection.

6.138 His mother did not believe that Mr D's use of cannabis had a direct impact on his mental health, although she recognised that it was not helpful. She said that he had abstained for three weeks in the community and she had not seen a change in his mental health. The family reported issues with Mr D while on leave. He was using his leave to sit in the car on the drive, talking to himself. The neighbours had called the police when he had spent time at his own home, because he was shouting in the street.

6.139 The family felt under pressure from Mr D to support his leave and to tell the Ward that leave was going well. The Ward told the family that they were exploring the option of transferring Mr D to a rehab ward for extended assessment.

6.140 Over the next week Mr D continued to be dishevelled in appearance and was responding to unseen stimuli. Mr D's family continued to visit Mr D on the ward but were not supporting escorted leave. He did access escorted leave with ward staff.

6.141 His father attended the ward round on 1 May 2019. At this point Mr D agreed to a referral to Acorn Ward, the rehabilitation ward.

6.142 On 2 and 4 May 2019 he had escorted leave with a member of staff from the ward and his father. By 5 May 2019 his care plan recorded that Mr D was established on olanzapine orodispersible 10mg. It also said that Mr D did not believe that he needed medication and that he had been non-compliant in the past. Mr D's father took him out on leave from the ward on 6 May 2019.

6.143 Mr D's parents and the CCO attended the ward round on 7 May 2019. There was a discussion about the transfer to Acorn Ward. Mr D did not believe that

he needed to be in hospital and wanted to be supported in the community by EIP. His lack of insight into his mental health problems was identified as a barrier to this. He also wanted his father to find him somewhere else to live because of the problems that he was having with the neighbours at his address. The plan from this ward round was for leave, escorted by ward staff, to continue, if there was a definite therapeutic purpose. His medication was to remain the same. A referral was to be made to Acorn Ward. This referral was completed by the CCO on 8 May 2019.

6.144 Over the next week Mr D accessed leave with staff, and on two occasions they were joined by his father. Female staff raised concerns about Mr D being over familiar with them while on leave. Mr D continued to be observed responding to unseen stimuli. On the 12 May 2019 Mr D went on escorted leave with his mother. He returned to the ward late.

6.145 His self-care began to improve, on 10 May Mr D was escorted to the barbers to have his hair unmatted, he presented appropriately and interacted socially, at times possibly over friendly introducing himself by name and asking others their name. A further appointment was made for the following Monday and on 13 May 2019 he was escorted by staff from the community team to have his hair braided.

6.146 On 14 May 2019 Mr D was observed masturbating in the garden while looking at the windows of the female section of the ward. He was asked to stop by staff and moved to another part of the garden. His Section 17 leave was reviewed on 15 May 2019 and he was to be allowed two hours escorted leave.

6.147 A mental state assessment was completed before Mr D left the ward for one hours leave with his mother in the evening on 16 May 2019. Earlier in the day he had leave away from the ward supported by staff. It was noted that he appeared to be settled and was not responding to unseen stimuli. The risks identified with his leave were illicit substance use, his vulnerability, and possible violence and aggression. Mr D was asked to provide a urine sample, but it was questionable what he provided (orange juice) and he was asked to provide a second sample. When he returned to the ward there were no concerns from his mother or the ward staff. Mr D did not appear to be under the influence of substances.

6.148 Mr D's mother supported leave on 17 May 2019. The following day she had a telephone conversation with the RC and confirmed that she was willing to support two hours escorted leave for Mr D. However, when he went on leave that day, he returned to the ward 30 minutes late. Mr D went on leave with his mother the following day, 18 May 2019, and was due to return to the ward at 3pm.

Absent without leave

6.149 At 1.30pm on 18 May 2019 Mr D's mother notified the ward that he had left the house while she was upstairs and that he was not answering his phone. The ward asked his mother to search the local area, but he was not found. The ward asked her to remain at home in case he returned. He had not

returned by 3.10pm and the ward reported him missing to Cumbria Constabulary.

6.150 Over the next few days there was regular contact between the family, the Ward and the CCO. On 19 May 2019 his father told the Ward that he thought Mr D might have gone to Blackpool. He had gone there previously, before he had gone to prison.

6.151 By 20 May 2019 it had been established that Mr D had a phone, plenty of money and his bank card. His father had shared Mr D's bank details with the police. There had been no sightings of Mr D at the local train station or shops, and he had not returned to his home address.

6.152 Police had identified Mr D as a high-risk missing person because of his potential risk to others due to his sexualised behaviour. They were interested in speaking to him about a sexual assault that took place in a park near his home address the evening of the day he went AWOL. The police were planning to issue a press release.

6.153 On 22 May 2019 Mr D's father told the ward that there had been sightings of Mr D on the train network and he was potentially in Morecambe or Carnforth. He reported that Mr D had shaved off his beard and bought some female clothing. These had been reported through train company staff. His father had passed this information to the police. His father was thinking of going to Blackpool to look for Mr D as he thought that was where he was heading.

6.154 On 23 May 2019 there was a phone call between the Dova Unit ward manager and senior managers from the Trust. The plan from this call was for Mr D to be detained to a male PICU ward when he was found. The outcome of his conversation was recorded on RiO[69] but no details about reasoning for the decision.

6.155 Mr D's father found him in a bank in Blackpool on 25 May 2019. He called the police and Mr D was taken to Victoria Hospital, Blackpool. There were no male PICU beds available in the Trust and a bed was found at Cygnet Health Care, Kent. A practitioner from the ALIS team went to Blackpool and gave Mr D's Section 3 MHA papers to the police. They completed a brief mental state assessment.

6.156 Mr D was transferred to Cygnet Health Care, Kent in a private ambulance.

6.157 A MARE meeting was held at Dova on 29 May 2019. Mr D was in Bearsted Ward, Cygnet Health Care, Maidstone by this time This was attended by the CCO, the Mentally Disordered Offenders Coordinator and the mental health liaison police officer. The meeting discussed and agreed the actions to be put in place when Mr D was found. This included the local police to be notified should he be given leave from the ward or return to live in the local area. This information was to be shared with Bearsted Ward. A non-urgent referral was to be made for a forensic assessment. The meeting did not consider any risk

[69] *RiO is the electronic clinical record system.*

that Mr D might pose to his immediate family beyond the need for a police marker to be placed on his own home address.

Cygnet Health Care

6.158 Mr D arrived at Cygnet Health Care, Kent (Bearsted Ward), at 5.55am on 26 May 2019. There is an admission nursing entry in the electronic clinical notes. We were unable to view the initial medical clerking and were later told that this was in a separate paper record, which was not supplied with the records when requested. The nursing entry identified Mr D's risk as: AWOL from Dova Unit, physical aggression and possession of a knife, fixation on young family member and sexually inappropriate behaviours.

6.159 There was a telephone call between the Dova Unit and Bearsted Ward that day. The contact details for Mr D's parents were given to Bearsted Ward.

6.160 Mr D's mental health paperwork was reviewed and updated following his arrival at Bearsted Ward. The date for the review of the Section 3 was recorded by an administrator as 14 June 2019. This date was incorrect and the correct review date, as identified in the referral papers, was 14 July 2019. There was a plan in place for a Managers Hearing on 12 June 2019.

6.161 He was seen by the Responsible Clinician (RC) on 28 May 2019 to complete an assessment of his capacity to treatment. Mr D was not willing to engage with him and several times asked him to leave.

6.162 Mr D was given the opportunity to attend the occupational therapy planning meetings on most weekdays during his admission. This would have allowed him to plan the ward activities that he would like to access each day. He either declined to attend the planning sessions, said that he would and then did not attend, or attended too late to participate.

6.163 He declined to take part in activities on the ward, with the exceptions of playing football on one occasion and briefly attending a smoothie making session. Mr D did not engage in an assessment of his occupational therapy needs, although he did complete an interest checklist on 10 June 2019.

6.164 Mr D did not engage with the psychology sessions available to him. He attended only two groups sessions, one of which was a coping skills group on 12 June 2019. Following this session it was noted that he was talking about "chem trails" and conspiracy theories. He attended an assertiveness skills group on 13 June 2019.

6.165 Mr D spent long periods of time in his bedroom while he was on Bearsted Ward and he had limited engagement with the staff on the ward. On one of the rare occasions that he engaged with the ward staff, they noted that when they got into deeper conversation with Mr D, his psychosis started to emerge.

6.166 There were three ward rounds, held on 29 May 2019, 5 June 2019 and 12 June 2019. In these meetings Mr D talked about wanting to move to Blackpool and expressed dissatisfaction with the care team in Barrow. He was noted to

show an understanding of his mental health issues and he was prepared to take medication.

6.167 On 5 June 2019 the RC stated that they did not understand why Mr D had been sent to a PICU and thought that Mr D was in recovery. The intent from this meeting was to renew Mr D's detention under the Act the following week.

6.168 A care plan was developed by the MDT on 5 June 2019, but Mr D refused to sign it. It stated that Mr D was to be provided with one-to-one time to explore triggers and gain insight into his admission. Psychology were to work with him to develop a Positive Behaviour Support[70] plan. Also, that once his mental state stabilised, he was to be transferred to an acute mental health ward.

6.169 The following day Trust bed management were informed that Mr D was ready for 'step-down'. The Trust did not have a bed available for him and asked Cygnet Health Care to look for a bed for him within their network. A referral for the Cygnet Health Care referral hub was completed by the Bearsted Ward doctor based on the information available in the original referral to Cygnet. It is to be noted that this doctor had not met Mr D and had no personal knowledge of him. The referral form identified the correct date for the review of the Section 3 (14 July 2019).

6.170 A bed was identified for Mr D at another Cygnet Health Care Unit, but they were only willing to accept him if Bearsted Ward completed a review under the MHA and renewed his detention under Section 3. This was because they believed that the Section 3 was due for review on 14 June 2019. Bearsted Ward said that they were not able to do this until the beginning of the following week.

6.171 Mr D spoke to EIP in Barrow on 6 June 2019. He said he did not want to go back to Dova Unit and requested a transfer to Blackpool. He asked for a new CCO as he felt his current one was delaying his discharge. Mr D was told that he would need an address in Blackpool to transfer there and this would need to be discussed as part of discharge planning. He was told that his requests would be shared with the psychosis lead and his CCO.

6.172 The CCO spoke to the Bearsted RC on 11 June 2019. The CCO was concerned that the ward had taken the decision to allow Mr D's section to lapse. The RC said that this decision had been made because Mr D was showing no signs of psychosis. The CCO challenged this stating that the ward round notes shared with them said he was responding to unseen stimuli. The RC said that Mr D was "rapping", and pointed out to the CCO that there had been no risk incidents since his admission to PICU, he had not required medication (PRN) and was presenting as being insightful and had capacity.

6.173 The CCO said that they did not believe that Mr D would remain on the ward as an informal patient and that he would stop taking his medication if he was not

[70] *Positive behaviour support (PBS) is "a person centred framework for providing long-term support to people with a learning disability, and/or autism, including those with mental health conditions, who have, or may be at risk of developing, behaviours that challenge.* https://www.cqc.org.uk/sites/default/files/20180705_900824_briefguide-positive_behaviour_support_for_people_with_behaviours_that_challenge_v4.pdf

monitored. The RC told the CCO that Mr D wanted to move to Blackpool, and they were asked to get Mr D's consent for a referral to Adult Social Care (ASC).

6.174 A review of the START[71] risk assessment was completed in the ward round on 12 June 2019. A moderate risk of self-neglect was identified and a low risk of violence, self-harm, suicide, unauthorised leave, substance, misuse and being victimised. This review document has not been fully completed, and there are sections with no information.

6.175 In the ward round on 12 June 2019 the decision was taken to not renew Mr D's detention under Section 3 and to discharge him home. This decision was taken because Mr D was showing no overt signs of psychosis or perceptual abnormalities. He was thought to have insight into his mental health issues and was willing to take his medication following discharge.

6.176 The ward round considered his parents to be supportive of discharge based on the letters that they had submitted in anticipation of the Managers Hearing planned for the 12 June 2019. The RC told the meeting that they had spoken to the CCO and told them that they did not think it was necessary to renew the Section 3 "regardless of what happened in the last admission…has to go by his presentation whilst on this ward." Mr D was reported to have been happy with the outcome of the ward round.

6.177 Bearsted Ward did not inform Mr D's parents of the plan to discharge him, he told his mother in a telephone call. His mother spoke to the CCO about the discharge, who said that they would complete an incident report about the "unplanned", "unsafe" discharge. The CCO told Mr D's mother to let the team know when Mr D arrived back in Barrow and that they would complete a 48-hour review. They also checked that she had the contact numbers for the out-of-hours services, should she need their support.

6.178 The CCO had previously made a referral to ASC for Mr D, they requested an update on the progress of this referral now that he had a discharge date.

6.179 After 4pm on 13 June 2019 the Bearsted Ward doctor contacted the CCO and informed them that Mr D had been discharged from the ward and was returning to his mother's address. The Cygnet notes record that the CCO did not raise any concerns at this time. The CCO notes do not have a record of this call, though it was referred to at interview.

6.180 Mr D was discharged from Bearsted Ward with seven days discharge medication and a discharge summary. He travelled home to Barrow in a private ambulance with a driver, arriving at about 3am.

[71] *Manual for the Short-Term Assessment of Risk and Treatability (START), Version 1.0 (consultation ed.) Ontario, Canada, Port Coquitlam, BC: St. Joseph's Healthcare Hamilton; Forensic Psychiatric Services Commission; Webster C, Martin M, Brink J, Nicholls T, Middleton C, 2004.*

Post-discharge care

6.181 On 14 June 2019 the CCO notified Cumbria Constabulary that Mr D had been discharged from hospital and was now living at his mother's address.

6.182 The CCO spoke to Mr D's mother and agreed to complete a 48-hour review if she was able to support Mr D to attend the EIP team base before 5pm.

6.183 Mr D attended the 48-hour review supported by his mother. He was well-kempt and wearing clean clothing. He said that he was willing to take his medication and the CCO was to arrange for a prescription to be provided by his GP, Mr D said that he was not experiencing any side effects, although he did feel "heavy" for a couple of hours after taking his medication. The CCO was to let Mr D know once the arrangements had been made for a joint appointment with ASC. Mr D told the CCO that he wanted to move to Blackpool. He also requested a change of CCO but following discussion agreed to remain with the current CCO. There were no risk issues identified. Mr D's mother was reported to be happy with his presentation.

6.184 The CCO sent an email to ASC on 17 June 2019 to make arrangements for a joint visit to complete an assessment. They also sent an email to the GP requesting a prescription for Mr D and shared the Cygnet Health Care discharge summary. They followed this up with a phone call the following day to check that the email request for the prescription had been received and was being processed.

6.185 The CCO provided Mr D's mother with an update about the prescription and the ASC referral on 18 June 2019. They said that if they had not heard from ASC by the end of the week, they would make arrangements to see Mr D. His mother reported that Mr D was doing well, though there were a few minor issues. However, he was taking his medication and had plans for the future.

6.186 Mr D spent the following day out with his father and a friend of his father. His mother called into the house later, and discovered Mr M injured and Mr D in distress.

6.187 Mr D was later arrested on suspicion of the murder of his father.

7. Analysis of mental health care and treatment

7.1 The terms of reference require us to review the following areas of practice in relation to the mental health care and treatment provided to Mr D:

- Care and treatment
- Inter-agency working and communication
- Risk assessment
- Serious incident review and action plan progress.

7.2 Each of these areas will be examined using the subheadings of the terms of reference. We have also developed further detailed headings that have emerged following our analysis of the issues.

These are:

- Care and treatment plans
- Cygnet Health Care inpatient care
- Discharge from Cygnet Health Care
- Medication
- Substance misuse
- Risk assessment
- Family involvement and carer support
- Safeguarding
- Use of the Mental Health Act.

7.3 As part of the overall report we will consider the quality of both health and social care assessments on which decisions were based and actions were taken.

7.4 We will also include compliance with local policies, national guidance and relevant statutory obligations as part of our analysis.

Care and treatment plans

"Undertake a critical review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence, with a focus on the period from March 2018 to the incident occurring in June 2019.

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

Consider the quality of both health and social care assessments on which decisions were based and actions were taken".

7.5 Mr D had the following diagnoses:

- January 2018, HMP Preston Mental Health In-Reach Team (MHIRT): Paranoid Schizophrenia
- August 2018, Early Intervention in Psychosis pathway (EIP): first episode psychosis
- December 2018, Hadrian Unit: psychotic illness
- January 2019, Hadrian Unit: schizophrenia (working diagnosis)
- March 2019, Dova Unit: schizophrenia
- June 2019, Bearsted Ward: no record of his diagnosis.

HMP Preston

7.6 Mr D was admitted to the health care wing of HMP Preston for assessment of his mental health following concerns raised by the prison staff about his bizarre behaviour on 24 February 2018. The concerns were first raised on 27 December 2017, but Mr D initially refused to see the mental health team and was seen on the 14 January 2018. This assessment concluded that he was not experiencing mental health problems.

7.7 He was assessed while on the health care wing by the visiting consultant psychiatrist on 31 January 2018. Their conclusion was that Mr D's presentation suggested schizophrenia with gradual insidious onset. They requested a hospital assessment for Mr D.

7.8 This assessment was completed by Guild Lodge on 28 February 2018. The assessment concluded that Mr D did not meet the threshold for detention under the Mental Health Act (MHA). They recommended that Mr D should remain on the health care wing for further assessment.

7.9 The visiting consultant psychiatrist discussed medication with Mr D on 6 March 2018. The plan following the review was to await the outcome of Mr D's upcoming trial. If Mr D was sentenced to remain in prison, they would consider prescribing aripiprazole. If Mr D was acquitted the MHIRT team was to share information with Mr D's GP about his admission to H1 and the plan to prescribe an antipsychotic medication.

7.10 Mr D's trial took place on 12 and 13 March 2018. He was released from court on 13 March 2018.

7.11 Mr D's release from prison was discussed at the prison mental health teams multidisciplinary team (MDT) meeting on the day of his release. They were aware that he had been released back into the community.

7.12 Neither of the prison health care services shared any information with Mr D's GP about the assessments of his mental health problems completed while he was detained in prison. There was no policy guidance about information sharing after prison release.

7.13 The provider of mental health services at HMP Preston and HMP Forest Bank has changed in this time and is now Spectrum Community Health CIC.[72]

Finding 6 – Spectrum CIC

The prison health care records note that information about mental health assessment and treatment should be conveyed to Mr D's GP to support a referral to secondary mental health services. This was not done, and it is not clear why, however, there was no policy guidance about information sharing after prison release.

Recommendation 3

Prison health care providers must ensure that systems are in place to share secondary prison health care consultations and information with GPs on discharge or release.

Care in the community

7.14 Community mental health services were responsive to Mr D's care and treatment needs following the referral made by his GP on 5 June 2018.

7.15 Mr D was accepted for assessment on the EIP pathway within the Community Mental Health and Recovery Team. He was assessed and treated under the Care Programme Approach (CPA).

7.16 The Trust Care Co-ordination Policy (Care Programme Approach & Care Management) v2 (August 2018) states that:

"An individual deemed to have complex needs, a higher risk profile and/or requiring multi-agency input should be placed on CPA".[73]

7.17 The Trust Care Co-ordination Policy (Care Programme Approach & Care Management) v2 (August 2018) is applicable to all service users with complex needs and identifies the four main elements of CPA, "as providing:

- Systematic arrangements for assessing the health and social care needs of people accepted into specialist mental health services.
- The formation of a care plan which identifies the health and social care required from a variety of providers.
- The appointment of a care coordinator to keep in close touch with the service user and to monitor and coordinate care.
- Regular review and where necessary, agreed changes to the care plan".

[72] *Spectrum CIC is a not-for-profit social enterprise, providing health care services on behalf of the NHS and Public Health. https://spectrumhealth.org.uk/*

[73] *Care Co-ordination Policy (Care Programme Approach & Care Management) August 2018.*

7.18 The policy requires that care plans are subject to regular review and where necessary changes made to the plan. It states that care plans should be subject to review at a minimum of six-month intervals.

7.19 The Care Coordinator (CCO) is described as being pivotal to the success of CPA and the responsibilities of the role include:

- "Complete a holistic assessment of the service user's needs including risk.
- To ensure the prompt and appropriate circulation of risk information, care plans etc to those who need to know.
- To identify strengths of service users, and those of their Carers, where appropriate.
- To collaborate with service users, carers, and others as appropriate, in developing and implementing a risk management plan for the service user.
- To collaborate with service users, carers, and others as appropriate, in developing a care plan for the service user in line with the Care and Treatment Pathways.
- Ensure high quality care is delivered in accordance with care pathways relevant for the service user, his or her condition and adapted in such ways that they provide consistent personalised high-quality care.
- To facilitate timely access to help, advice and support of other agencies including Adult Social Care (ASC), housing and educational/training institutions.
- To schedule and convene timely reviews of care plans, and urgent reviews as required.
- To complete relevant CPA/care management documentation as required.
- To provide reports to MHA Managers Appeals and MHRT as appropriate in line with agreement with Adult Social Care".

7.20 Mr D was allocated a CCO in June 2018 and they remained responsible for his care until the time of the offence. The CCO followed the CPA Policy and completed a CPA review with Mr D and his father on 9 October 2018. They also attended and contributed to the CPA review completed on Dova Unit on 22 March 2019.

7.21 They had regular planned contact with Mr D and were responsive to requests for support outside this planned contact. They worked with Mr D in a way that encouraged him to engage with them.

7.22 In addition to completing a CPA assessment and care plan for Mr D, the CCO completed a Comprehensive Assessment of Risk Mental States (CAARMS). This established that Mr D had been experiencing symptoms of problems with his mental health since 2014/15.

7.23 The CCO maintained contact with other agencies who came into contact with Mr D, for example the offender manager at the Probation Service. They made appropriate referrals to other services and for additional assessments for Mr D. This included three referrals to the local authority for an assessment of Mr D's social care needs under the Care Act. They supported the only social care assessment that Mr D agreed to. This assessment identified that Mr D had been experiencing a long duration of untreated psychosis.

7.24 They also made a timely referral to Acorn Ward when it was established that Mr D needed a referral to a rehabilitation ward.

7.25 The CCO was responsive to changes in Mr D's presentation while he was in the community and made referrals for assessments under the MHA in July, August and December 2018.

7.26 The CCO maintained regular contact with Hadrian Unit, Dova Unit and Bearsted Ward while Mr D was detained. They attended ward rounds when possible and if unable to attend would contact the wards before and after the ward rounds, to provide information and get feedback, respectively. We noted that they were proactive in approach and could be relied on to complete any actions they agreed to promptly. The CCO was responsive to and supportive of Mr D's parents, promptly returning their calls and telephoning them to keep them up to date with plans for Mr D's care and treatment.

7.27 The CCO was proactive in the support that they provided to Mr D with regard to his compliance with medication. On one occasion they contacted the pharmacy to ensure that he had collected his medication. On another occasion that had a conversation with Mr D about strategies to ensure he took his medication, e.g. putting an alarm on his mobile phone as a reminder.

7.28 The CCO was proactive in working to get Mr D transferred to an acute bed nearer to his home when he was in Kent, liaising with bed management and asking for regular updates.

7.29 When Mr D was discharged from Bearsted Ward the CCO completed the 48-hour review within 24 hours. They arranged for his medication to be available to him before his discharge medication ran out. They notified the police that he was living at his mother's address and checked that his mother knew how to get support should she have any concerns about Mr D out of hours.

Finding 7 – Trust EIP

The care and support provided to Mr D and his family by Early Intervention in Psychosis pathway (EIP) and especially the Care Coordinator (CCO) was of a high standard. They sought to understand Mr D's mental illness and provide him with treatment in the least restrictive manner.

Hadrian Unit

7.30 Hadrian Unit is a mixed sex ward. From the day of his admission on 14 December 2018 Mr D displayed inappropriate behaviour towards female patients and staff. There were a number of incidents involving Mr D including:

Date	Issue
14/12/18	Inappropriate behaviour with a female patient. The nursing staff discussed this with Mr D and he demonstrated that he understood the ward boundaries.
19/12/18	Grabbed a female patient by the neck and tried to kiss her.
19/12/18	Seen staring at the female corridor.
20/12/18	Naked on the ward corridor.
1/1/19	Found in a female patient's bedroom.
4/1/19	Looking at female staff inappropriately.
5/1/19	Found in a female patient's bedroom (had been found in bed with female patient in the past).
7/1/19	Observed looking through the window of the female lounge.
7/1/19	Female patient reported that Mr D was following her round the ward and wanted to report this to the police. Inappropriate behaviour towards a female member of staff was also reported that day.
9/1/19	Observed cuddling a female patient.
12/1/19	Over familiar with staff and patients, especially females.

7.31 He spent time on enhanced observations because ward staff were concerned that he would be vulnerable to accusations from woman with whom the ward believed he was indulging in inappropriate sexual behaviour. It would be expected within the Safeguarding Policy that there should have been a formal concern raised. None of these concerns resulted in safeguarding referrals being made for either patient. These incidents were managed through conversations with Mr D about his behaviour, locking the female corridor to minimise his access to it and placing him on enhanced observations. However, Mr D reported that he enjoyed enhanced observations, so this was discontinued.

7.32 Most of the incidents involved one female patient but none of these resulted in safeguarding referrals being made for either patients. Our analysis of this can be found in the safeguarding section.

7.33 Mr D was involved in an incident with another patient on the ward. He was observed to punch the other patient and had his hands around their neck.

This incident was reported to the police because the staff concluded that this was driven by behaviour and not by mental illness.

7.34 He had a working diagnosis of schizophrenia and was initially prescribed aripiprazole. This was changed to zuclopenthixol following reports of side effects from Mr D. See below for our analysis of Mr D's medication.

7.35 Mr D's care and treatment were of a good standard while he was on the Hadrian Unit. Formulation meetings and medical reviews were held that included his parents and CCO. They either provided information in phone calls with the RC or attended the meetings.

7.36 The Unit completed assessments of Mr D's risk in line with Trust policy. Risk assessment and management is explored in the section titled Risk assessment and includes our concerns about the management of his behaviour towards women and how this was managed.

7.37 Medication options were explored with Mr D. The ward started a conversation with Mr D about the use of depot medication.

7.38 The MHA was used appropriately to manage Mr D in the least restrictive manner. On the 7 January 2019 an Approved Mental Health Practitioner (AMHP) completed a review of Mr D and concluded that Mr D did not meet the criteria for detention under the MHA when the Section 2 MHA was due for review. The Section would be allowed to lapse on 10 January 2019, unless the RC decided to discharge him from hospital before that date.

Leave from Hadrian Unit

7.39 Mr D requested leave from the Hadrian Unit to go home for the festive period. Before his request was agreed there was a meeting with the RC to discuss the risks. Immediately before Mr D left the ward for leave a mental state assessment was completed by ward staff.

7.40 He was on leave from 24 to 29 December 2018. The RC completed a medical review with Mr D's father present. Leave was agreed following this meeting, during which potential risks to his mother (who he would be spending the leave with) were explored. The RC also checked that the family were aware that they could contact the police or the ward should they have any concerns about Mr D, and that there was always the option to return him to the ward.

7.41 When Mr D returned to the ward a medical review was completed with him and his mother, to obtain feedback on how the leave had gone, His mother reported to the ward that the leave had not gone well. She reported that he had been "hyper" while at home, not sleeping for a 24-hour period. She also said she thought that he was unwell and a further deterioration would put other people at risk.

7.42 His father told the CCO that Mr D had threatened him in the car on the way to his mother's because he was unwilling to take Mr D with him to his own home. His father gave into the pressure to take Mr D to his home and he believed

that while they were there Mr D was searching for cannabis. He also reported that Mr D had been smoking cannabis while on leave.

7.43 The Hadrian Unit managed Mr D's leave well. Completing assessments before he left the ward and on his return. They also ensured that his family knew what the options were should they have any concerns about Mr D while he was on leave.

Dova Unit

7.44 Dova Unit is a mixed sex ward. Mr D continued to exhibit inappropriate sexual behaviours on the ward. He was openly masturbating, and he made the female staff feel uncomfortable. The care team could have considered a transfer to a male only ward. While there may not have been one available in the Trust, they could have considered an out-of-area NHS or private bed. There is no record of this having been discussed.

7.45 The ward was engaged with Mr D's parents and involved them in the decisions about Mr D's care. They were responsive to their concerns and made adjustments to Mr D's leave from the ward to reflect their concerns.

7.46 In our view, accepted best practice for the prescribing of medication to a patient who was known to be resistant to medication and had been non-compliant in the past would be to consider depot medication.

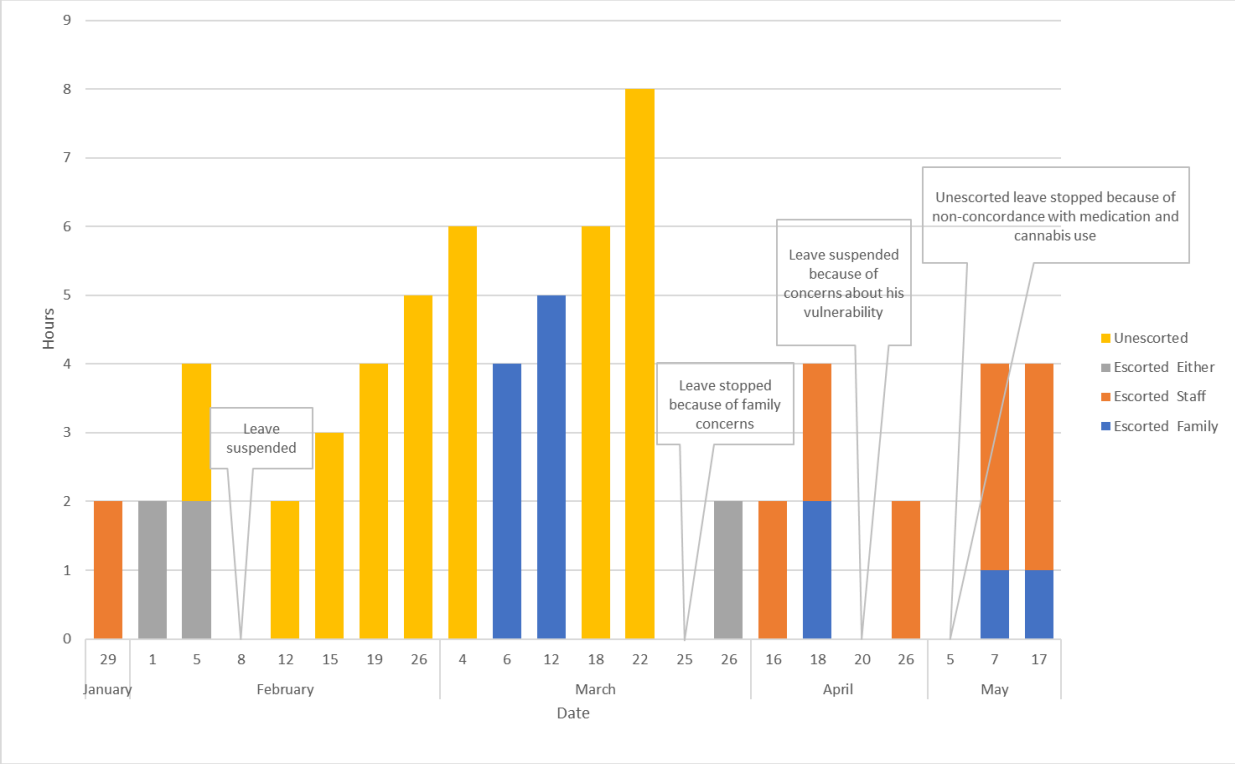
7.47 Mr D's risk assessments did not reflect the families concerns about the risk that Mr D exposed them to. They complained several times to the ward about Mr D being aggressive and threatening towards them and that he coerced them into saying that leave had gone well when it had not.

7.48 Mr D was provided with a good standard of care and support while on Dova Unit. Once it was established that Mr D was making little progress on the ward a plan was developed to transfer him to a rehab ward for further assessment of his mental health.

Leave from Dova Unit

7.49 Mr D was given Section 17 MHA leave from Dova Unit. The details of the leave agreed and the times that it was suspended are in the graph below. This does not reflect the leave that Mr D actually took. He was rarely given leave escorted by ward staff, because the ward staff did not feel comfortable taking Mr D off the ward because of his inappropriate behaviour.

7.50 The conditions of the Section 17 MHA leave were that Mr D refrained from using cannabis while off the ward.



7.51 We have identified a number of issues about how Dova Unit managed Mr D's leave, which we set out below.

- Ward staff were reluctant to support Mr D to use escorted leave. This was because the ward staff were unhappy with his inappropriate behaviour towards female staff, e.g. looking them up and down. This should have led to a review of the Section 17 MHA leave decision.
- When Mr D was given unescorted leave from the ward there was initially no boundaries set about the times he could leave and return to the ward. This resulted in him leaving the ward late afternoon and spending the evening/early night-time at his elderly grandparents. Boundaries were put in place once this was raised with the ward. The ward should have taken a common-sense approach to the timings of Mr D's unescorted leave, not allowing him to leave the ward mid-afternoon when he has been allocated eight hours leave from the ward. Leave was always at the discretion of the nurse in charge on the ward.
- The ward did not support Mr D's family to understand what escorted leave was and how they could manage Mr D. There was an assumption that he would be in the company of a family member at all times. This was not always the case and on one occasion he was left alone in his home by his father.
- The family said they felt unable to challenge Mr D because he could become violent and aggressive. The ward did not act protectively for the family or in consideration of the coercive control Mr D may have been exerting on them.
- The ward did not consistently complete a mental state assessment for Mr D before he went on leave from the ward. They did not complete

mental state assessments when he returned to the ward from leave. Nor did they ask his parents for feedback on how the leave had gone.

7.52 We have concluded that Mr D placed pressure on his family to feedback that leave had gone well. As a result, they only reported his behaviour to the ward following incidents that caused them concern, e.g. when he spent the whole of a session on leave in his grandfather's car revving the engine until the battery ran down.

7.53 We conclude that the AWOL could not have been prevented or mitigated against based on Mr D's previous behaviour. Mr D did not have a history of not returning to the ward following leave. Nor were there any conversations noted with him in which he talked about not returning to the ward.

Finding 8 – Trust care and treatment risk assessment

Sexually disinhibited behaviours were not well managed on the mixed sex ward and consideration should have been given to moving Mr D to a male ward.

Risk assessments and clear care plans were not used in the decision to grant Section 17 leave, or to agree the use of leave when he requested it.

The family was not sufficiently involved in managing risk during the use of leave.

Recommendation 4

The Trust must ensure that there is clear guidance to be followed for the care of patients who present as sexually disinhibited, which adheres to national guidance on same sex accommodation.

Recommendation 5

The Trust must ensure the use of Section 17 leave is supported by robust risk assessment and clear care plans that are agreed by the multidisciplinary team (MDT) and families as appropriate.

AWOL and transfer to Cygnet Health Care, subsequent bed management

7.54 Mr D did not return to Dova Unit from escorted leave with his mother on 18 May 2019. His mother notified the ward that he had gone missing and they went on to notify the police and senior managers and completed an incident form in line with the AWOL Policy.[74]

[74] *Absence without Leave, and Missing Patient Policy*

7.55 Initially the police identified Mr D as a person of interest in regard to a sexual assault in a park close to his home address. They later concluded that there was nothing to link him to the assault.

7.56 Mr D's father maintained contact with Dova Unit throughout his absence. He was active in the search for Mr D. He provided the ward with information about reported sightings of Mr D on 22 May 2019 and told them that he believed him to be in Blackpool. His father was told that when Mr D was found it was likely that he would be admitted to a Psychiatric Intensive Care Unit (PICU). This was because of the difficulties that there had been managing Mr D on an open acute ward and his risk of absconding.

7.57 On 23 May 2019 there was a conversation between the Dova Unit ward manager and senior managers in the Trust. It was concluded that when Mr D was found he should be admitted to a male PICU bed. The record of this conversation on RIO is scant. It would not have supported anyone reviewing the decision to understand the clinical and safety reasoning behind it. It is also to be noted that the CCO was not included in the decision to admit Mr D to a PICU bed once he was found.

7.58 Mr D's father found him in a bank in Blackpool on Saturday 25 May 2019. Mr D was taken to Blackpool Victoria Hospital by officers from Lancashire Constabulary. Mr D was not admitted through A&E or seen by the local mental health services, which is not in keeping with expected practice. It is reported that the police took Mr D to a hospital cafe and waited for a response from the Trust.

7.59 While Mr D was in Blackpool, he had appeared very vulnerable and it is reported that he had been assaulted and robbed. It is also reported that he had gone home with men whom he did not know.

7.60 The Trust 'bronze on call'[75] requested that the Access and Liaison Integration Service (ALIS) team, who are responsible for looking for beds out of hours, find a PICU bed for Mr D. The Trust Bed Management Policy states that a patient should be assessed/triaged by the Trust PICU before a PICU bed is sought for a patient. This did not happen, and we were told by the on-call manager that there were senior level instructions to direct him to be admitted to a PICU when he was found.

7.61 There were no PICU beds available in the Trust so the ALIS team looked for an out-of-area PICU bed. A bed was located at Cygnet Health Care in Maidstone, Kent and they accepted Mr D. A practitioner from the ALIS team was sent from Barrow to Blackpool to give the MHA paperwork to the police, so that it could go with Mr D to Kent. When the practitioner saw Mr D, he completed a brief assessment but did conduct a detailed review of his mental state and risk assessment. Mr D was transferred to Maidstone, Kent by private ambulance.

[75] *Bronze on call refers to NHS operational management structures.*

7.62 The Trust reviewed its bed state daily, but no bed became available to transfer Mr D back. On 6 June 2019 Cygnet Health Care determined that Mr D was ready to be stepped down to an acute mental health bed. There were no beds available in the Trust and Cygnet Health Care were authorised to find Mr D a bed in their network.

7.63 An acute bed was identified for Mr D at Cygnet Health Care, Barnsley, on Friday 7 June 2019. This was 150 miles from Mr D's home. Following a conversation with Bearsted Ward, Cygnet Health Care, Barnsley said that they would admit Mr D once his detention under the MHA had been reviewed. This was because they believed (incorrectly) that Mr D's Section 3 MHA was due to expire on 12 June 2019. Bearsted Ward said that they could not review the Section until the beginning of the next week and asked if the bed could be held until then.

7.64 We have found that the internal referral for an acute bed within the Cygnet network contained the correct date for the review of Mr D's detention, which was in July 2019.

7.65 Cygnet Health Care Referral Line referred Mr D to Cygnet Health Care, Darlington on 10 June 2019. There were no beds available.

7.66 A PICU assessment/triage was not completed for Mr D before he was transferred to a PICU bed. It is unclear what the basis of the decision for a transfer to a PICU bed was. Following interviews with staff we understand that the decision was based on him being identified as a person of interest by the police.

7.67 There was no mental state assessment completed before Mr D was transferred to Cygnet, Kent. The mental health practitioner from ALIS was sent to Blackpool to deliver the MHA paperwork but did not complete an assessment.

7.68 Mr D's family were not consulted before he was transferred to Maidstone, Kent. This was 346 miles from his family and his community care team.

7.69 There is no evidence available that the Trust considered moving patients around to create a PICU bed to accommodate Mr D within the Trust, or closer to his home.

7.70 The Trust provided Cygnet Health Care with good quality information to support the referral, including an updated GRiST and documents that clearly identify the correct date for the review of his Section 3 MHA.

Finding 9 – Trust care and treatment: PICU beds

The rationale behind the plan that agreed to transfer Mr D to a male Psychiatric Intensive Care Unit (PICU) bed was not adequately described in his clinical notes, and alternative admission options were not discussed.

Recommendation 6

The Trust must demonstrate that referrals for Psychiatric Intensive Care Unit (PICU) and/or out-of-area treatment include clinical assessment and recommendations.

Sexuality

7.71 The first time that Mr D suggested he had a female element to his character was on 11 January 2019, while he was on Hadrian Unit. He insisted he was "not gay".

7.72 We did not find evidence of Mr D's emerging issues regarding his sexuality being explored with him. This was not discussed on either the Hadrian Unit or Dova Unit to establish if this was a genuine aspect of his personality, that he had chosen not to share with family and the community team, or if this was an element of his mental illness/psychosis.

7.73 When Mr D was found in Blackpool, he was wearing some items of women's clothing. Mr D told Bearsted Ward that he wanted to move to Blackpool because he believed that he would be able to mix with like-minded people and this opportunity was not available in Barrow.

7.74 Had Mr D been admitted onto a rehab pathway we would have expected this aspect of his behaviour to have been explored as part of a more in-depth assessment of his mental health, in keeping with expected best practice.

Finding 10 – Sexuality

Opportunities to explore Mr D's expressions of sexuality and its importance in relation to his mental health were missed.

7.75 NICE guidance[76] for treatment of psychosis provides evidence-based guidance on the following best practice elements of treatment:

- Service user experience
- Physical health
- Support for carers
- Peer support and self-management
- First episode psychosis

[76] *NICE CG178: Psychosis and schizophrenia in adults: prevention and management (2014).* https://www.nice.org.uk/guidance/cg178/chapter/1-Recommendations

- Subsequent acute episodes of psychosis or schizophrenia and referral in crisis, and behaviour that challenges
- Psychological interventions
- Pharmacological interventions
- Using depot/long-acting injectable antipsychotic medication
- Employment, education and occupational activities.

7.76 We have benchmarked Mr D's care in relation to these standards in the table at Appendix E. The results of this benchmarking show that psychological interventions were offered, carer's support or family interventions (discussed below); employment, education or occupation support; or robust physical health support. Medication management is discussed in detail below.

Finding 11 – Trust care and treatment NICE guidance

The care and treatment offered to Mr D from his first presentation was of a good standard, in line with expected policy and practice in EIP and NICE guidance.

The Care Coordinator (CCO) provided excellent continuity of care and communicated regularly with family members.

Inpatient Cygnet Health Care

7.77 Mr D was admitted to Cygnet Health Care, Kent on 26 May 2019. They were provided with up to date information about Mr D, including an updated GRiST. The referral information identified the review date for Mr D's detention under Section 3 MHA as 14 July 2019. This date was calculated by the MHA administrator without reference to the referral paperwork as 14 June 2019. All of the decisions about Mr D's care and treatment on the ward were based on this incorrect date.

7.78 Bearsted Ward did not explore with Mr D what he had done while he was AWOL. They did not seek to understand his vulnerability while he was in Blackpool. They took at face value what Mr D told them about his desire to move to Blackpool.

7.79 A care plan was devised for Mr D on 5 June 2019 that he refused to sign. No reason for this is recorded. This care plan required nursing staff to engage with Mr D one-to-one to explore his triggers and gain insight into his admission. Despite this Mr D was allowed to isolate himself and spend long periods of time in his room, it is not clear why. This resulted in the care team not having an understanding of Mr D's mental health issues and psychosis.

7.80 He did not engage in the daily planning meetings on the ward or join the activities available on the ward. He did not engage with psychology sessions available on the ward, attending part of two sessions towards the end of his admission.

7.81 The ward rounds failed to identify and explore incidents with Mr D that the care team had documented in the clinical records. Mr D was well versed in masking the symptoms of his mental illness and further exploration of these incidents would have provided the care team with greater insight into his mental health. On the 31 May 2019 the nursing staff noted that when in deep conversation Mr D showed evidence of psychosis. On 5 June 2019 Mr D became aggressive and threatening towards the nursing staff on the night shift when they could not provide him with toast. Towards the end of a psychology group meeting on 12 June 2019 Mr D started to talk about "chem trails" in the context of a conspiracy. Later that day he was observed looking female members of staff up and down in a way that made them feel uncomfortable.

7.82 The care team did not develop a relationship with Mr D's CCO or parents. This was a missed opportunity for the care team to get some historic context of Mr D and his behaviours. In particular it would have been useful for the Cygnet team to know that he was very adept at masking his psychotic symptoms.

7.83 The CCO found it very difficult to make contact with the ward and this resulted in them sharing information via the MHA administration team.

7.84 This lack of engagement with Mr D, combined with a lack of professional curiosity about incidents, resulted in the care team not having a true understanding of Mr D's mental health issues and risk.

7.85 At admission Cygnet Health Care, Kent recorded the incorrect review date for Mr D's Section 3 MHA. The consequence of this was that Cygnet Health Care, Doncaster, would not accept Mr D for admission to an acute bed until a review was completed of his detention. However, the correct date for the review of his detention under the Act was clearly recorded in the referral documents from the Trust. This correct date was replicated in the Cygnet Health Care internal referral for an acute mental health bed on 6 June 2019.

7.86 The care records maintained were not adequate. Most of the nursing records were scant. The occupational therapy and psychology notes outline in detail an activity planned and then, on most occasions, Mr D did not engage with the activity. This is misleading and confusing to the reader. This was replicated in the ward round records.

7.87 The care and treatment provided to Mr D on Bearsted Ward fell short of that which we would have expected as part of the continuation of a CPA plan of care.

Discharge from Cygnet Health Care

7.88 Due to an administrative error, the expiry of date of Mr D's Section 3 MHA was incorrectly logged within the internal systems at Cygnet Hospital Maidstone. Although it was recorded that the Section 3 MHA was due to expire on 14 June 2019, the actual expiry date was 14 July 2019.

7.89 The origin of this error appears to be the initial MHA scrutiny conducted by the MHA Administrator Assistant. The MHA Administrator Assistant had been in post for approximately seven months, dividing her time between a main role as Medical Secretary, and three hours per week allocated to being an MHA Administrator Assistant. They had received appropriate in-house support and supervision to undertake this role. After the MHA Administrator Assistant had calculated the expiry date, there was no secondary scrutiny or checking of the dates by more senior staff.

7.90 Regardless of this error, the RC expressed the view that Mr D had made sufficient clinical improvement in his mental state and his risk had reduced sufficiently for him to be discharged from hospital on 13 June 2019.

7.91 Clinical notes indicate that during the majority of Mr D's admission on Bearsted Ward, the plan was to transfer him back to his local area to an acute bed. Even as late in the process as 12 June (with discharge subsequently taking place on the following day) the ward round records state that "he could be supported in an acute ward closer to the Blackpool or Barrow area".

7.92 Mr D was technically discharged from the Section 3 MHA before it was due to end, although the RC at the time considered that it was ending, and he was in fact not renewing it. Any planned step-down to an acute ward would have depended on Mr D's willingness to remain in hospital voluntarily.

7.93 The RC stated as part of investigation interviews that Mr D's discharge on 13 June 2019 was appropriate based on improvements in his mental state and risk, and that there was evidence in the clinical records to support this.

7.94 However, from our review of the notes we have identified other considerations that we consider should have been discussed:

- Evidence to indicate possible residual psychotic symptoms.
- Pattern of increased hostility and risk towards his family following his Section, which he believed them responsible for
- His very limited engagement with staff and therapies, refusing most invitations to groups.
- He had been hostile to staff, and made female staff feel uncomfortable, even the day before discharge.
- There had been no use of escorted Section 17 MHA leave to test any apparent clinical improvement.
- The local team who knew him well had established a plan for him to be referred for long-term rehabilitation while remaining detained under Section 3 MHA.

7.95 Even if, as staff believed, Mr D was clinically ready for discharge, the available evidence indicates that the planning for discharge was extremely limited:

- The RC was not identified or contacted prior to discharge.

- The perspective of the family regarding his continued detention was not adequately considered.
- Although he was discharged to his mother's house, she was not involved in discussion of the discharge plan and arrangements for supporting him in the community. There was no consideration of his past risk behaviour towards women.
- A Section 117 MHA discharge planning/CPA meeting did not take place.
- There is no evidence that the risk issues which were highlighted in the Multi-Agency Risk Evaluation (MARE) were considered.
- Cumbria Constabulary were not notified when Mr D was discharged back to his mother's address, as had been directed in the MARE action plan.
- There is no evidence that the CCO's concerns about discharge were acknowledged.
- The 'Notification of Discharge' document signed off jointly by the Ward Manager and Ward Specialty Doctor does not state any specific discharge plan for ongoing care and support in the community.

7.96 There was no formal discharge CPA review meeting or Section 117 MHA meeting prior to discharge, which is in contradiction of the Cygnet Health Care Discharge Policy. It transpired that the GP details held for Mr D were not accurate. A full discharge summary was later sent to the CCO, although a full discharge letter was never provided to the GP or community consultant psychiatrist.

7.97 The error in the presumed Section 3 MHA expiry date did not necessarily contribute to limited discharge planning, because the expiry date was well known for several weeks, and the RC clearly expressed the view that Mr D had improved clinically to an extent that made discharge more appropriate than a Section 3 MHA renewal. Section 3 MHA renewal was considered but not sought or deemed necessary by the RC.

7.98 As part of the internal investigation, the RC indicated that if he had known there was another month until the expiry of Section 3 MHA, he would have sought step-down to an acute hospital bed. Within the records however it is clear that the correct date was known, as the referral for an acute bed was made by the Specialty Doctor, and this referenced the correct Section 3 MHA expiry date of 15 July 2019.

7.99 The Cygnet Health Care Transfer and Discharge Policy[77] is dated as issued in May 2020. We have not been provided with the policy which was in use in June 2019. The policy refers to the expected follow-up arrangements under Section 117 MHA:

[77] *Transfer and Discharge/CPF 1.12 (20) [A-A-238]/RMDs/JD*

"the [Cygnet] named nurse will arrange a discharge CPA meeting with the local care coordinator and all involved members of the multidisciplinary team, other professionals, the individual and advocate/ relatives if appropriate, must be invited to the discharge planning meeting.

The individual must be made clearly aware of the support that will be provided immediately after discharge; this may feel like a very vulnerable time for the individual, and therefore it is important that the individual knows:

- Who will provide support in the community?
- When their first appointment with the support will be.
- What to do if they need to contact services before their first appointment".

7.100 It is reasonable to assume that the previous policy included these standard expectations. We have also been provided with a discharge checklist dated November 2019, which is a comprehensive checklist of tasks and communications which should take place before discharge. There was no checklist completed for Mr D.

7.101 We have evaluated the discharge from Cygnet Health Care, Kent against the Discharge from PICU protocol and it is clear that Mr D's discharge did not meet any of the requirements.

Protocol Requirement	Yes/No	Comment
All admissions to the PICU should have an Estimated Discharge Date (EDD) agreed at the first ward round.	No	Each of the 3 ward rounds identifies the earliest date of discharge as in 4 weeks.
All admissions to the PICU should have an Estimated Pathway for Discharge agreed at admission e.g. Acute Hospital, Home, Low Secure.	No	There was no agreement about the pathway for the admission. Had the care team liaised with the local care team they would have had an understanding of the plan to transfer Mr D to a rehab ward for ongoing assessment and treatment.
All plans for discharges should be captured in the Discharge Planning Care Plan and be reviewed every week.	No	There was no Discharge Planning Care Plan.
Once a patient is considered ready for discharge, local teams and family members should be involved in planning for a safe discharge as soon as possible. Where possible	No	The only contact that the care team had with the local team was to inform them that Mr D was being discharged. The care team had no direct contact with his parents. The care team

this should involve a CPA meeting or phone call with all parties involved.		made assumptions about his parent's views based on the letters that they had submitted in anticipation of the Managers Hearing.
If the PICU MDT feel discharge home is appropriate this should be discussed initially with the Medical Director and Hospital Manager.	No	There were no discussions with the Medical Director or the Hospital Manager about the plan to discharge Mr D home.
Following review with the Medical Director and Hospital Manager, if it is still felt appropriate to discharge the patient home, discussion with the local team, funders and family should take place to agree next steps.	No	There were no discussions with the local team, funders or Mr D's family to agree the next steps towards discharging him home. They were not given the opportunity to disagree with the discharge and as such the next requirement became redundant.
In the event the local team and/or family disagree, this should be escalated to Medical Director and Hospital Manager and a case conference organised to discuss options.	N/A	
If a patients' Section is due to expire and they are deemed 'undetainable' by the RC and MDT, a case conference with local team and family should be organised as soon as possible.	No	See previous comments about contact with the local team and family about the discharge.

7.102 Prior to discharge, the focus of the conversations with Mr D were about his desire to move to Blackpool. Consequently, the need to be referred to Adult Social Care (ASC) was discussed in this context and not his need for support to ensure that he was compliant with his medication.

7.103 Mr D was not provided with a discharge plan, beyond being told that his CCO would see him once he was home.

7.104 The letters written by Mr D's parents to the Managers Hearing planned for 12 June 2019 are those of caring parents who wanted the best for their child. Without the ward having a relationship with the parents, or an understanding of the events of the previous 12 months, indeed the previous few years, these could be read as being supportive of a discharge home.

7.105 In our view the decision by a distant clinical team to discharge Mr D directly to the community was flawed. No consideration was given to the potential risk to Mr D and his family. We question the decision to rescind a Section 3 MHA and discharge directly from a PICU, based on three weeks' contact with a patient who had a considerable history of violence. Notwithstanding the CCO's expressed concern about potential discharge. The CCO was so concerned about the discharge that they completed an incident report.

7.106 Mr D was Section 117 entitled, and as such the local authority and the Clinical Commissioning Group (CCG) should have been aware of his discharge and aftercare arrangements should have been established. The Cygnet internal investigation did identify that a formal discharge meeting regarding section 117 entitlement should have taken place to identify and plan Mr D's community care needs.

Finding 12 - Cygnet Health Care management

Mr D was discharged from Cygnet Health Care Maidstone without due regard to

- Cygnet Health Care Discharge Policy
- Risk information and Multi-Agency and MARE agreements
- Legal expectations of Section 117 MHA
- Family perspective

Medication

7.107 Antipsychotic medication was first considered for Mr D in March 2018 when he was detained in HMP Preston. He was released from prison before he could be prescribed any medication. The prison MHIRT team did not send a discharge summary to his GP, therefore the GP was unaware of Mr D having mental health issues and the need for medication.

7.108 Mr D was prescribed dispersible olanzapine 5mg following blood tests and an ECG on 8 August 2018. This was the only time that Mr D would agree to blood tests and an ECG. Later he would not agree to blood tests because he said he was a Jehovah's Witness and he would not have an ECG because he was concerned about electrical currents.

7.109 There is evidence to suggest that the only time that Mr D was compliant with his medication while in the community was when he was under the care of the Home Treatment Team (HTT). Even then, on one occasion it was thought that he tried to spit out the medication into a drink.

7.110 The CCO was proactive in supporting Mr D to take his medication. When his mother raised concerns about him not taking his medication in September 2018, the CCO contacted the pharmacy to check that he was collecting his

medication. On another occasion the CCO advised him to set him an alarm on his phone to remind him to take his medication.

7.111 When Mr D was on Hadrian Unit his medication was reviewed and discussed with him. He was not willing to accept risperidone but would accept aripiprazole. He was prescribed and titrated onto aripiprazole dispersible. By 25 January 2019 he was being given aripiprazole 25mg in the morning.

7.112 In January 2019 there were discussions with Mr D about prescribing a depot because of concerns about his compliance with oral medication. He was not willing to accept this because of his religious beliefs.

7.113 Following his transfer to Dova Unit his medication was reviewed again and he was titrated onto oral zuclopenthixol 30mg daily. This medication is not available in a dispersible form. It is available as a tablet or oral drops.

7.114 Mr D's family expressed concerns that he was not taking his medication during March 2019. His father told the Ward that he had found medication in his car that he believed belonged to Mr D. This concern resulted in a note being put on his medication chart advising staff to be vigilant when observing Mr D taking his medication.

7.115 There were discussions with Mr D about his medication on 16 April 2019. He did not want to be prescribed aripiprazole again but agreed to olanzapine. He was prescribed olanzapine orodispersible 10mg.

7.116 When Mr D was admitted to Bearsted Ward he was willing to accept olanzapine.

7.117 Mr D was provided with information about his medication options and he was included in the decision-making process. He was identified from his initial contact with mental health services as being a patient who was reluctant to accept medication. This resulted in him being prescribed medication in a dissolvable form to aid compliance.

7.118 However, on 12 February 2019 while he was on Dova Unit Mr D was prescribed zuclopenthixol. This is not available in a dispersible format and he was prescribed it in tablet format. This resulted in a reduction in Mr D's compliance.

7.119 There was a three-week delay between the family expressing concerns about Mr D not taking his medication and his medication being changed to olanzapine orodispersible 10 mg.

7.120 There are reasonable doubts about Mr D's compliance with medication for the eight weeks that he was prescribed zuclopenthixol. It could be that the failure to see an improvement in his presentation could be attributed to poor medication compliance.

7.121 According to NICE guidance[78] 'Psychosis and schizophrenia in adults: prevention and management', oral antipsychotic medication should be offered for "people with first episode psychosis as part of care plans. After the first month, the care team should monitor symptoms, distress, impairment and level of functioning (including education, training and employment) regularly".

7.122 The preparation for prescribing medication for Mr D was in keeping with the guidance, but there is a lack of evidence of effective monitoring and prescribing. Our review of records on both Dova Unit and Bearsted Ward suggest evidence of acute psychosis which was only partially treated.

Finding 13 – Trust care and treatment: medication

Mr D was not treated assertively with antipsychotic medication.

There was an absence of appropriate care plans to address his lack of compliance and refusal to consider depot medication.

Recommendation 7

The Trust must ensure that evidence-based treatment plans are in place, that are in line with NICE treatment guidance 'Psychosis and schizophrenia in adults: prevention and management' (2014).

Substance Misuse

7.123 Mr D had been using cannabis since the age of 17. He would smoke it, ingest it or use cannabis oil.

7.124 In October 2018 EIP signposted Mr D to Unity[79] for support with his substance misuse, but at that time Mr D did not want a referral for his cannabis use.

7.125 In February 2018 while Mr D was on Dova Unit the staff discussed his substance misuse with him. Mr D continued to be reluctant to stop using cannabis. Mr D expressed the belief that cannabis supported his spirituality and that it was "medication". He denied using other psychoactive substances.

7.126 While Mr D was on Dova Unit one of the conditions of leave from the ward was that he refrained from using cannabis. There is no evidence available to support the proposition that he complied with this condition, or that staff checked to ascertain whether he had used cannabis. He often returned to the ward smelling of cannabis. On one occasion his family reported that he had spent all of his leave in his grandfather's car, smoking cannabis.

[78] *Psychosis and schizophrenia in adults: prevention and management. Clinical guideline [CG178] Published date: 12 February 2014 Last updated: 01 March 2014.* https://www.nice.org.uk/guidance/cg178

[79] *Unity is the Alcohol and Drug Recovery Service for Cumbria.* https://www.gmmh.nhs.uk/unity/

Finding 14 Trust care and treatment: substance misuse

Mr D's use of cannabis was long standing and endemic. He was not motivated to change his habits and stop using cannabis. Services signposted him to substance misuse services. They had conversations with him about his cannabis use and encouraged him to consider stopping.

This was within normal policy expectations.

However, there was a failure to explore his psychotic beliefs in any depth, and to follow through on the conditions expected of Mr D while on leave, including abstaining from cannabis.

Risk assessment

"Review the adequacy of risk assessments and risk management, including specifically the risk posed to others and how this was shared.

Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review".

Risk assessment under the care of the Trust

7.127 While Mr D was under the care of the Trust it was using the GRiST risk assessment tool. The egrist.org website defines GRiST[80] as "a web-based decision support system designed to help practitioners assess and manage risks associated with mental health problems, including suicide, self-harm, self-neglect, vulnerability, and harm to others".

7.128 It has been used in the NHS since 2013. In their report on the assessment of risk in mental health organisations in 2018, NCISH[81] found that out of 85 NHS mental health services, only four used GRiST. Therefore, despite it being in existence since 2000, it has not been widely adopted by NHS mental health services.

7.129 A previous Domestic Homicide Review (DHR), in 2015, involving a patient under the care of the Trust expressed concerns over the use of GRiST as the risk tool for the Trust. The report strongly recommended that Trust consider an independent review outside of the organisation to review all risk assessment tools and the policies and procedures that support the use and delivery of such tools.

[80] *The egrist.org website states GRiST helps mental health practitioners, service users, and carers detect and explain risks associated with mental health problems to reduce suicides, self-harming, neglect, and violence.*

[81] *The assessment of clinical risk in mental health services, National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), October 2018. https://sites.manchester.ac.uk/ncish/reports/the-assessment-of-clinical-risk-in-mental-health-services/*

7.130 We were told that such a review had not been completed in response to this recommendation, but it was unclear why.

7.131 In October 2019 the southern part of Cumbria Partnership NHS Foundation Trust (CPFT) and Lancashire Care Foundation Trust merged to become Lancashire and South Cumbria Foundation Trust (LSCFT). South Cumbria services have continued to use GRiST. We have been told that there is an intention for services to adopt the Enhanced Risk Tool developed by LSCFT. It is anticipated that this will be adopted by South Cumbria services in early 2021.

7.132 The 2018 NCISH report includes the following in their clinical messages:

> "Risk is not a number, and risk assessment is not a checklist. Tools, if they are used (for example as a prompt or a measure of change), need to be simple, accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.
> Risk assessment processes are an intrinsic part of mental health care but need to be consistent across mental health services. Staff should be trained in how to assess, formulate, and manage risk. On-going supervision should be available to support consistency of approach. There is little place for locally developed tools".

7.133 We support these views and believe they should be considered when the Trust implements its proposed risk assessment processes. In particular, they need to ensure that the issues identified with GRiST are not replicated in the Enhanced Risk Tool.

7.134 GRiST assessments were completed once by ALIS, when Mr D was initially referred to mental health services, twice while he was under the care of Early Intervention in Psychosis pathway (EIP), three times while he was detained to Hadrian Ward and a further nine times while detained to Dova Unit.

7.135 The GRiST assessments completed by ALIS, EIP, Hadrian Unit and Dova Unit demonstrate a comprehensive risk formulation and risk narrative about Mr D's behaviour. His principal risks were identified as his risk to others and a risk of a further deterioration in his mental health. The main triggers were identified as cannabis use increasing his paranoid thoughts, the financial problems associated with his cannabis use and a deterioration in his mental health. He was consistently considered to have no insight into his mental health and the need for assessment and treatment. They state that he had previous involvement with the police for drugs and violent offences.

7.136 His protective factors were identified as a willingness to engage in an assessment and a supportive family. The GRiST risk summaries for all of the assessments completed for Mr D identified no risk of suicide, or self-harm as low.

7.137 The risk of harm to others and damage to property fluctuated over time. The key time that this risk was considered to be low was in June 2018, medium July 2018 to January 2019, low February 2019 to May 2019 and high in June 2019.

7.138 The risk of harm to dependents was either rated as low or not known.

7.139 The risk of self-neglect was considered medium from June 2018 to January 2019, February 2019 to May 2019 it was rated as high and then reduced to medium at the end of May 2019.

7.140 Mr D's vulnerability was rated as medium until February 2019 when it was increased to high.

7.141 The safety plans in the GRiST documents describe the service response to his risks. However, while these are appropriate, they are not safety plans that could have been used by Mr D or informed the family response to any escalating concerns that they may have had about Mr D.

7.142 Notwithstanding this the CCO and EIP ensured that the family had all of the contact details for the services of who they could contact for help if they had any concerns about Mr D in working hours and also out of hours. They also repeatedly told his parents that they should contact the police if they had any concerns about his levels of aggression or felt threatened.

7.143 The GRiST completed by Dova Unit following Mr D going AWOL identified the concerns that the Ward had about his vulnerability because he would not have access to his medication.

7.144 The GRiST assessments considered Mr D's family to be supportive and did not identify or consider any of the reported incidents of aggression towards Mr D's family, all of which were recorded in the clinical notes. Namely:

- The incident reported to the police about an assault on his stepsister in 2012.
- Reports that Mr D had pushed his mother down the stairs (date unclear).
- While Mr D was detained to Dova Unit his family reported that his grandparents were frightened of him.
- Mr D was aggressive towards his mother and grandmother when they visited for his birthday in January 2019, while on Hadrian Unit.
- The hostility Mr D showed towards his father on Dova Unit on 20 January 2019. Mr D's feelings were so aroused on this occasion that he needed PRN medication to calm him.
- In a Dova Unit ward round in March 2019 the team expressed concerns that limiting Mr D's access to cannabis would increase aggression.
- The hostility that Mr D showed to his parents following the MHA Tribunal in April 2019. This was because they had made disclosures about his behaviour to the Tribunal that they had not anticipated would be shared with Mr D.
- In the meeting with the Dova Unit care team on 26 April 2019 the CCO noted that Mr D's attitude to his family had been "hostile and aggressive to them at times" when concerns have been shared with the

ward. They went on to note that "All staff would be wary of risk to family."

- In May 2019 the ward risk assessment states that his family felt pressured into saying that Mr D was doing well. They told the ward that they felt intimidated by him when he was on leave from the ward.
- It is also noted in the clinical records that Mr D held his father responsible for his detention under the Mental Health Act (MHA) and his ongoing detention to Dova Ward.

7.145 The GRiST assessments completed also failed to identify Mr D's risk to women following the incidents on Hadrian and Dova Ward.

7.146 This failure to record and review these incidents did not support a clear understanding of the family dynamic or Mr D's attitude/potential risk to his parents. Furthermore, the MARE on 12 July 2018 made a reference to his father "colluding" with Mr D, this is not referenced or explored in the risk assessments or clinical notes.

7.147 In addition to the GRiST, shorter risk assessments were completed as part of the formulation meetings while Mr D as an inpatient.

7.148

Finding 15 – Trust risk assessment

Trust mental health services completed regular assessments/reviews of Mr D in line with the requirements of the Trust's Risk Policy.

The GRiST[82] tool is challenging for staff to complete and difficult to interpret. It is a stand-alone document, not included on the clinical record (RiO). GRiST is series of screens and is colour coded to identify the elements assessed at that review. Mr D's GRiST assessments are very detailed, and this can be a challenge to the reader, and a summary would have been helpful.

There is no section in the assessment that invites staff to consider the risks that a patient might pose to adult family members.

Trust services did not complete a thorough assessment of Mr D's risk to his family. The family told care professionals on many occasions about feeling threatened and intimidated by Mr D, and that they had concerns about the risk he presented to his grandparents.

Recommendation 8

Any changes to the risk assessment tools used by the Trust should be informed by current research and recommendations from independent

[82] *GRiST is a web based risk assessment tool. https://www.egrist.org/*

bodies. Any newly developed tools should be based on current knowledge and informed by independent experts in risk assessment in mental health services. They should also be subject to independent evaluation by experts in risk assessment before they are implemented.

Use of MARE

7.149 The Multi-Agency Risk Evaluation (MARE) framework applies to service users with a mental illness who do not meet the criteria for Multi-Agency Public Protection Arrangements (MAPPA) Level 2 and 3 but are assessed as posing a risk of serious harm to the public. The Trust, Cumbria Constabulary, National Probation Service and Cumbria County Council Adult Social Care have an agreed pathway for patients subject to MAPPA/MARE. This is described in the MAPPA/MARE Pathway Policy (January 2017).

7.150 EIP identified that Mr D posed a risk of serious harm to the public and the MARE process was appropriately used to assess and manage his risk with MARE meetings being held on 12 July 2018 and 29 May 2019.

7.151 The minutes of both meetings demonstrate a clear assessment of and understanding of Mr D's risk to himself and others, and good multi-agency planning to manage his risk. Both meetings assessed Mr D's risk of harm as high: "there are identifiable indicators of risk of harm. The potential could happen at any time and the impact would be serious."

7.152 The completion of the actions from the MARE meetings was monitored by the Mentally Disordered Offenders Coordinator. Mr D's parents were aware of the MARE meetings, although they were not invited to attend, as is usual practice.

7.153 The minutes for the MARE on 29 May 2019 were shared with Bearsted Ward and the staff told us that they had received and read them. We have concluded that these minutes should have caused the care team to reconsider the plan to allow Mr D's detention under Section 3 to lapse, and that transfer to an acute ward would have been in keeping with the risk assessment.

Finding 16 – Multi-Agency Risk Evaluation (MARE)

MARE structures were used appropriately to share multi-agency information about Mr D's risk.

The actions of the agencies were monitored by the Mentally Disordered Offenders Coordinator as expected.

MARE information was made available to Cygnet but not used to inform the risk assessment and discharge planning process.

Risk assessment under the care of Cygnet Health Care

7.154 The START is a concise clinical guide used to evaluate a client's or patient's level of risk for aggression and likelihood of responding well to treatment which is used by Cygnet Health Care to assess and manage the risk of patients under their care. Health care professionals are often asked to assess the risk for aggressive or adverse events among their patients and clients.

7.155 The ward completed a START assessment for Mr D on 6 June 2019. This did not extend much beyond the tick box front page. The supporting narrative was brief, and we presume that this was completed for another patient because it contained information about the patient being AWOL in Spain, which did not apply to Mr D.

7.156 Mr D was identified as being of moderate risk of violence, unauthorised leave and self-neglect. The management strategies to manage these risks were to offer Mr D one-to-one sessions to help him express his feelings, offer PRN medication and for him to be nursed one-to-one when in the courtyard.

7.157 This was reviewed on 12 June 2019, again by a tick box form with little supporting narrative. The tick box components have been completed. The risk history details are cursory, and the risk formulation section is blank (as is the service user comments section). The only medium risk identified for Mr D was self-neglect and the management strategies remained the same. The layout of the START assessment is cluttered and hard to navigate. The pages for risk formulation and risk history are good, although the layout of the formulation page is cluttered and would be easier to use if it was laid out differently.

7.158 Mr D's risk was not adequately reviewed in ward rounds and incidents were not discussed, e.g. his aggressive behaviour when staff declined to give him extra food.

7.159 There was a lack of professional curiosity about the events that happened while Mr D was in Blackpool. The GRiST indicates that Mr D had been the victim of a mugging and had been robbed.

7.160 The assessments completed while Mr D was detained to Cygnet Health Care were inadequate. They failed to identify and address risks identified in the referral made to the unit by CPFT. These included, violence and historic use of a knife, use and supply of class A drugs, known and observed masturbating in public places, over-sexualised behaviour, reports of being fixated on a young family member, potential acts with his dog, dressing as a woman in public, being vulnerable and having money stolen from him.

7.161 The MARE meeting minutes and action plan were shared with Cygnet and when interviewed staff demonstrated that they were aware of it. However, this did not prompt a review of Mr D's risk or impact on discharge planning. Furthermore, Cygnet Health Care, Kent did not follow the plan and notify the police when Mr D was discharged back to his mother's address. This was done by the CCO following his arrival home.

Finding 17 – Cygnet Health Care risk assessment

The risk assessment and reviews completed by Bearsted Ward were incomplete and did not fully reflect the known risks associated with Mr D that could be found in the referral documents, the GRiST and the Multi-Agency Risk Evaluation (MARE).

There was a lack of professional curiosity about the risks identified in the information shared with the care team by Mr D's home Trust.

The care team failed to identify Mr D's inappropriate behaviour towards the female staff on the ward.

The care team failed to re-assess his risk to staff following the incident of aggression towards staff.

Recommendation 9

Cygnet Health Care must ensure that the risks identified by local services are clearly visible in any risk assessment completed by Bearsted Ward, and that when risks are identified they are recorded and mitigation plans developed.

Family involvement and carer support

"Examine the effectiveness of the service user's care plan including the involvement of the service user and the family. Comment on how the family's views and concerns were addressed".

7.162 Mr D was an only child, although his parents had separated when he was young, they both remained very involved, providing him with care and support. He lived in a property owned by his father, who paid all the bills for the property.

7.163 While he was under the care of EIP his parents were provided with three carer's support sessions. These sessions included completing a Premorbid Adjustment Scale[83] to determine when Mr D had started to experience symptoms of mental ill health. In addition, they discussed how to support Mr D with medication compliance. His parents were provided with information about local support for carers. The last appointment was on 28 September 2018. His parents were aware that they could make another appointment for a carer's support session should they feel the need for one.

7.164 The CCO was proactive and reactive in their relationship with Mr D's parents. They were consistent in following through on all the actions that they agreed

[83] *The Premorbid Adjustment Scale (PAS) is a premorbid scale for use in schizophrenia, developed by the National Institute of Mental Health. Cannon-Spoor HE, Potkin SG, Wyatt RJ. Measurement of Premorbid Adjustment in Chronic Schizophrenia. Schizophrenia Bull. 1982;8(3):470–484*

with Mr D's parents. They listened to their concerns, provided them with support and acted as the conduit for information sharing with the inpatient facilities that Mr D was admitted to.

7.165 Mr D was transferred from the Hadrian Unit to Dova Unit without his parents being informed. This resulted in his family visiting Hadrian Unit following his transfer (this is a four-hour round trip).

7.166 Mr D's parents did not feel that they were listened to by the staff on Dova Ward, especially with regard to the management of his leave from the ward. At one point, Mr D was allowed long periods of time off the ward. He was allowed to go off the ward mid-afternoon which resulted in him staying off the ward until late evening. He was spending this time at his grandparents' home, staying for long periods until late evening and causing them stress. The Ward met with Mr D's parents and grandparents to explore their concerns and his leave was altered to manage the situation.

7.167 Mr D's parents were unhappy that disclosures that they had made to Dova Unit were shared with Mr D during the MHA Tribunal in March 2019. The possibility of this happening was not fully explored with his parents. They were not aware that the Tribunal had the power to disclose information that they had shared in confidence.

7.168 In the MARE meeting minutes for 12 July 2019 there is reference to his father "colluding" with Mr D, but there is no reference to this elsewhere in the clinical records.

7.169 Mr D was always seen by mental health staff in the community with either his mother or his father. While this may have hampered the ability of the staff to complete assessments of Mr D, it was recognised by the staff that without the support of his parents Mr D would not have engaged with mental health services.

7.170 The risks to Mr D's parents were not adequately assessed.

7.171 NICE guidance 'Psychosis and schizophrenia in adults: prevention and management'[84] advises that carers, relatives, and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments.

7.172 It is recommended that carers should be given written and verbal information in an accessible format about:

- Diagnosis and management of psychosis and schizophrenia
- Positive outcomes and recovery
- Types of support for carers

[84] *Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178]. Published date: February 2014.* https://www.nice.org.uk/guidance/cg178/chapter/Introduction

- Role of teams and services
- Getting help in a crisis

7.173 In our view, psychosocial education should have been provided for Mr D and his parents in understanding the nature of his diagnosis, how his family could support him, what could be expected in terms of recovery, and how medication may affect him.

7.174 The Trust CPA Policy states that "Carers form a vital part of the support required to aid a person's recovery. Their own needs will be recognized and directed for assessment through Adult Social Care in accordance with the Care Act 2014".

7.175 We have not found any evidence that referrals for carer's needs were forwarded for assessment, neither did we find any structures used to record any referrals for carers assessments.

Finding 18 – Trust family involvement

Family education and interventions, as outlined in NICE guidance 'Psychosis and schizophrenia in adults: prevention and management' (2014), were not provided.

Trust services included Mr D's parents in the decisions about his care.

Information about the support available to carers was provided to his parents.

Dova Unit were responsive to the concerns that his parents raised about the information shared by the Mental Health Act (MHA) Tribunal. The Ward met with his family and took the time to explain that they were not responsible for breaching the family's confidentiality. The Ward told the family that any sharing of information would be risk assessed.

Risk management considerations were not applied to his family.

Recommendation 10

The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment.

Recommendation 11

The Trust must ensure that it is recognised that supportive families may also be at risk of harm, and that comprehensive assessments and supportive plans are developed.

Safeguarding

"Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon".

7.176 The Trust policy describes the adult safeguarding threshold in line with the multi-agency procedures, this guidance describes the requirement to raise a safeguarding referral based upon cumulative incidents.

7.177 The Care Act 2014 defines an 'adult at risk' as someone over the age of 18 who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs);
- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

In relation to Mr D

7.178 During Mr D's admission to Hadrian Unit there were eight recorded instances of sexualised behaviour involving him and female patients. None of the incidents appear to have been reported as safeguarding concerns. There is nothing in the records to suggest that any of these incidents were considered in relation to safeguarding the female patients. The incidents were of varying severity and include:

- Possible sexual activity between Mr D and a female patient, however he denied this. This should have been reported as an incident and the Trust safeguarding team should have been consulted for advice. Care plans and risk assessments should have been updated to reflect sexual safety risks.
- Grabbing a female patient by the neck and kissing her, this should have warranted a safeguarding referral due to the nature and the severity of the incident. Patients within a mental health ward have the right to feel safe and the Trust has a responsibility to maintain their safety. A reported published by the CQC (2018) highlights this issue and offers guidance to Mental Health Trusts to maintain sexual safety in mental health inpatient wards.
- Female patient asked for the police to be called as she felt threatened and harassed by Mr D following her around the ward. In accordance with making safeguarding personal (Care Act 2014) this should have been considered as safeguarding.
- The accumulation of the eight instances should have warranted a safeguarding referral, the number of instances highlighted that the ward was not adequately managing the risk and was not able to keep

female patients safe. Therefore, a safeguarding referral should have been raised in accordance with Trust policy.

7.179 There was also an incident of physical violence towards a male patient where Mr D grabbed the patient by the throat and punched him. There is nothing in the records to indicate that a safeguarding referral was made or if the incident was reported in line with the incident reporting policy. Again, safeguarding processes should have been instigated.

7.180 There is evidence in the police Individual Management Review (IMR) that some of these incidents were reported to the police however they should have also warranted a safeguarding referral.

7.181 When risk was reviewed or handed over from one ward to another, the risks that were identified were risk of self-neglect and risk of violence. There is no reference to risk to others in the form of sexualised behaviour.

Finding 19 – Safeguarding 1

There is no evidence to support that safeguarding was considered in relation to the sexual safety of patients on the ward. There were at least three opportunities where safeguarding advice should have been sought or a safeguarding referral made.

The Trust policy with regard to cumulative risks was not followed and there is no evidence to show that any consultation with the Trust safeguarding team occurred.

In relation to grandparents

7.182 Concerns were raised by Mr D's uncle regarding him being a "danger" to his grandparents. The police raised an adult safeguarding referral on 7 June 2018 however this was raised naming Mr D as the adult at risk and not his grandparents. The referral was screened by the adult safeguarding team and not progressed due to there being "no identified care and support needs". While the decision not to proceed under a Section 42 enquiry[85] was the correct decision, the rationale had not been established; therefore, the decision should have been not to proceed due to no abuse and neglect.

7.183 There were five entries in the mental health records regarding the grandparent's fear of Mr D and one regarding concerns of Mr D's behaviour towards his grandparents on the ward. However, there was no comment regarding safeguarding for the grandparents. There was nothing to suggest that his grandparents had care and support needs which would warrant an adult safeguarding referral. However, there is no evidence that risk to

[85] *The Care Act 2014 (Section 42) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect.* https://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

grandparents was even considered despite both grandparents and parents expressing their concerns. Section 17 leave was continually granted in the knowledge that Mr D was spending most of this leave at his grandparents' home.

7.184 Leave was suspended in April however it was recommenced without any evidence that the risk to Mr D's grandparents had been assessed, there was no significant change in his presentation that would suggest the risk to the grandparents had been removed.

In relation to other vulnerable people/children

7.185 The family raised concerns regarding Mr D showing an unusual interest in a young family member. This was reported in the Trust IMR as "chasing her around the kitchen wanting a kiss". This should have been reported to Children and Families Social Care who would have required some assurance regarding the family's ability to keep the child safe while Mr D was on leave. Guidance was produced by the Royal College of Psychiatrists (2009) regarding the requirement for psychiatrists to consider the welfare of children in their discharge planning.

7.186 In order to consider children, adult mental health teams need to identify their existence, therefore all people coming into contact with mental health services should be asked if they have children or have regular access or contact with children. This must be recorded within the adult patient's records.

7.187 The clinical team were initially unaware that Mr D had contact with children during his leave, but once this was identified, leave was appropriately stopped. The notes make reference to the safeguarding team being consulted but there is nothing to support this action being completed.

7.188 There is no evidence that Mr D's father was an adult at risk, with care and support needs. There is therefore no expectation that there should have been any safeguarding considerations in relation to him. However, he had disclosed feeling afraid of Mr D and pressured to do things as a result of this, so the below finding is considered to also be applicable to his parents.

Finding 20 – Safeguarding 2

There is no evidence to suggest that risk to grandparents had been considered, this is despite the clinical team being informed that grandparents felt "frightened" and "scared" of Mr D. While the grandparents may not have met the criteria for an adult safeguarding enquiry (Section 42 Care Act 2014) there should have been a consultation with the Trust's safeguarding team to discuss the risk and how to manage this risk. This should have been completed prior to recommencing leave.

There is no evidence that any possible risk to children was considered.

Recommendation 12

The Trust must seek assurance that safeguarding supervision is accessible and provided to staff within ward environments in accordance with NHS England Safeguarding Accountability and Assurance Framework 2019.

Recommendation 13

The Trust must seek assurance that the Trust Safeguarding Service is made aware of Trust incidents where there is harm caused to a service user to ensure appropriate safeguarding oversight.

Use of the Mental Health Act

7.189 Use of the MHA was first considered in February 2018 when Mr D was assessed by staff for Guild Lodge. At that time, he was not considered to meet the threshold for detention under the Act.

7.190 Mr M was his 'nearest relative' under the MHA. He was initially reluctant to agree to have Mr D assessed under the Act because he had previously had a bad experience of the MHA being used to detain a close family member.

7.191 There was a six-month period when Mr D was under the care of mental health services in the community. There were four occasions when consideration was given to or an assessment was completed under the MHA.

7.192 During this time Mr D did engage with EIP and the Home Treatment Team while his mental health continued to deteriorate. On two occasions, June and August 2018, Mr D was not considered detainable under the Act because he was willing to engage with the team and accept treatment. On one occasion, July 2018, the requested assessment was not completed because the AMHP concluded that Mr D's parents were not in agreement with the assessment being completed.

7.193 Following the Mental Health Act Assessment (MHAA) on 2 August 2018, Mr D accepted support with medication from the HTT. He was discharged by the team on 29 August 2018. Mr D then became responsible for managing his own medication and would not allow his mother to observe him taking it.

7.194 His family expressed concerns about a deterioration in Mr D's mental health from the beginning of October 2018. However, Mr D was not displaying any of the behaviours that were causing his family concerns when he attended appointments. In an appointment on 12 November 2018 Mr D was able to rationalise his symptoms. At this appointment he demonstrated a willingness to engage in treatment by agreeing to an appointment with the EIP psychologist.

7.195 Concerns from the family increased over the next few weeks. Concerns were also raised with the CCO by Mr D's offender manager. Following an unannounced home visit by the CCO on 12 December 2018 a request was made for an MHAA. There was a plan to complete the assessment that evening. But this failed because Mr D refused to return to his home.

7.196 Mr D's father contacted the CCO the next day. He was very angry about the failed MHAA the previous evening. It was agreed that the assessment would be completed during the EIP appointment planned for 14 December 2018.

7.197 Mr D held his father responsible for this detention under the Act; we can only surmise that this is because he accompanied him to the appointment, and he was the 'nearest relative'. On 20 January 2019, Mr D was derogatory towards his father about his role in Mr D's Section. There is no record of any discussion about the potential for displacing Mr M as the Nearest Relative, as this appeared to increased his exposure to risk from Mr D.

7.198 Mr D was initially detained to the Hadrian Unit under Section 2 MHA. When this was reviewed the Approved Mental Health Practitioner (AMHP) concluded that Mr D did not meet the criteria for detention and the Section was allowed to lapse. We have concluded that Hadrian Unit managed this situation appropriately.

7.199 While Mr D was an informal patient, he requested to leave the Unit. The ward staff were successful in persuading him to remain on the ward. Had he refused to stay on the ward they had a plan to use Section 5(2) or 5(4) MHA to detain him while arrangements could be made for an assessment.

7.200 The use of the MHA was not discussed in sufficient detail with the family. The family would have benefitted from a clear understanding of the role of the 'nearest relative', Section 17 leave, the role and power of an MHA Tribunal and Section 117 responsibilities.

7.201 It is unclear if his parents were aware of the expectations with regard to supervising Mr D when he was on escorted leave with them. On one occasion when he was on escorted leave with his father the ward became aware that Mr D was at his home address and his father was on his way back from Blackpool. This should have been explored with Mr M to clarify the situation.

7.202 EIP supported Mr D in the least restrictive manner. Following his assessment under the MHA in August 2018 Mr D was supported for a month by HTT. When the family raised concerns in November 2018 Mr D agreed to meet with the team psychologist, demonstrating a willingness to engage in treatment. When Mr D's presentation continued to deteriorate the Care Coordinator

(CCO) requested a MHA assessment. Mr D refused to remain in his home, so it was not possible to complete the assessment. The CCO liaised with the AMHP and the assessment was completed in the planned care coordination appointment on 14 December 2018. While it had taken six weeks from the initial concerns of the family, this was not unreasonable given that Mr D gave the appearance of engaging with services.

7.203 Hadrian Unit managed the situation appropriately when Mr D was not considered appropriate for an MHA assessment when the Section 2 MHA expired. They had a plan in place if Mr D refused to remain on the ward as an informal patient.

7.204 Dova Unit did not manage Mr D's Section 17 leave effectively. They did not always complete mental state assessments before and after leave and did not actively seek feedback from his parents about how escorted leave had gone.

Finding 21 – Mental Health Act

The use of the (Mental Health Act (MHA) was not discussed in sufficient detail with the family.

Mr D's family were not made aware of the responsibilities of the 'nearest relative', the potential to be displaced, or the implications of agreeing to Section 17 leave conditions.

It was not made clear to them that information given in confidence could be disclosed by the Tribunal.

Recommendation 14

Trust and Adult Social Care staff must consider how best to communicate information to Nearest Relatives, so they can be assured that the Nearest Relative clearly understands their role and rights under the Mental Health Act. Simplified versions of written materials are recommended, where they are not already in use.

Recommendation 15

NHS England should share learning identified with the First Tier Tribunal (Mental Health) regarding providing guidance to families about how any confidential information they share may be used.

8. Serious incident review

8.1 The terms of reference require us to review the following areas in relation to the Trust internal investigation:

"Review the Trust post incident internal investigations and assess the adequacy of their findings, recommendations and action plans.

Review the progress that the Trust has made in implementing the action plan associated with their internal investigation".

8.2 The Trust internal report has been reviewed using our structured approach, which is detailed at Appendix C. We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency, NHS England Serious Incident Framework (SiF) and the National Quality Board Guidance on Learning from Deaths.[86] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

8.3 In developing our framework, we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Health Care Improvement RCA2 (or Root Cause Analysis and Action, hence 'RCA Squared') which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

8.4 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.
- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'.[87]
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.
- Actions do not have completion dates or meaningful process and outcome measures.

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[86] *National Quality Board: National Guidance on Learning from Deaths. https://www.england.nhs.uk/wp-content/uploads/2017/03/ngb-national-guidance-learning-from-deaths.pdf*

[87] *Marx, D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University Press, 2001.*

- The event review took longer than 45 days to complete.

8.5 Our detailed review of the internal report is at Appendix C. In summary we have assessed the 25 standards as follows:

- Standards met: 12
- Standards partially met: 4
- Standards not met: 9

8.6 We discuss our analysis below.

Analysis of Trust internal investigation

8.7 At the time of the incident, mental health services were provided by Cumbria Partnership NHS Foundation Trust (CPFT). CPFT asked that the investigation be undertaken by Lancashire and South Cumbria NHS Foundation Trust (LSCFT). In October 2019 South Cumbria mental health services transferred to LSCFT and LSCFT will be responsible for implementation of the action plan.

8.8 The CPFT Incident and Serious Incidents that Require Investigation (SIRI) Policy[88] describes three levels of investigation: concise, comprehensive and independent. It was noted that the internal investigation was commissioned as a 'Level 2 comprehensive investigation'. This is explained as:

"Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable. The investigation should be completed, and final report submitted to the CCG, within 60 working days of the incident being reported".

8.9 The investigation was carried out by the Head of Safety for LSCFT, supported by a lead pharmacist, lead nurse and a consultant psychiatrist.

8.10 The report was provided to this investigation in August 2020, over 12 months after the homicide. The report does not explain the time delay, and no clarification was provided at interview with the lead author. A number of reasons have been provided by Cygnet Health Care for the late delivery of the report:

- the investigator was experiencing work pressures due to staffing issues;
- the impact of COVID-19;
- the ongoing police investigation; and
- the time spent seeking to engage with Cygnet.

[88] *Incident and Serious Incidents that Require Investigation (SIRI) Policy, POL/002/006/001. May 2018*

8.11 NHS England (London) Investigation issued guidance in April 2019 on engaging with families after a mental health homicide.[89] This provides clear best practice guidance to mental health provider organisations and states that "families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation".

8.12 The report describes having contact with Mr D's mother in autumn 2019, but no evidence was provided of ongoing contact with or support for her. Contact was made with one of Mr M's brothers (contact details provided by the police) and he had no terms of reference to add and did not appear to want any further updates.

8.13 Mr D's mother was given the opportunity to contribute to the investigation and provided questions that were added to the terms of reference for the investigation.

8.14 The family of Mr D's father were not given the opportunity to contribute to the investigation or outline any concerns that they may have had about Mr D's care or the support provided to his father by services.

8.15 The report was not shared with Mr D's mother until October 2020, who then had an opportunity to comment on the findings. It is not clear whether these comments were incorporated into a further version of the report. Mr D's father's family were not given the opportunity to comment.

8.16 Mr D was not approached, initially on the advice of the police. In the interview with the LCSFT Head of Safety on 22 October 2020 it was reported that Mr D's consultant had been approached and he had said that Mr D was too unwell to be seen.

Adequacy of findings and recommendations

8.17 There were no care and service delivery problems explicitly identified, although contributory factors are noted. However, the investigation does not explore the overall leadership and management of care and treatment or the organisational systems/processes that underpin care and treatment in this case. For example, the investigation did not explore the systems/processes in place for monitoring the care and treatment of patients placed in out-of-area beds, and how plans were developed to return patients to a Trust bed.

8.18 The investigation describes the root cause as, "It is likely that the service user was not medicated at the time of his father's death given his belief that he was not ill and previous non-concordance with medication".

8.19 This statement does not describe a root cause because it is not supported by evidence, it is supposition.

8.20 A root cause can be defined as:

[89] *Mental Health-Related Homicide Information for Mental Health Providers April 2019.* https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

"The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-occurrence."[90]

8.21 The failure to describe a root cause has resulted in a missed opportunity to identify areas for learning.

8.22 There were five recommendations made, listed below:

8.23 Recommendation 1. That Missing Persons and AWOL procedure is adopted by South Cumbria inpatient units which includes that a risk assessment be undertaken regarding the likelihood of a patient going missing.

8.24 While this is a reasonable recommendation based on the findings, we consider that the systems for agreeing leave from an inpatient unit should also be revised. The policy and practices should ensure that there is robust risk assessment, care planning and contingency planning before Section 17 leave is agreed.

8.25 This would then minimise the risks of patients being granted leave when risks have been reported.

8.26 Recommendation 2. That the Missing Persons and AWOL procedure be reviewed to include the role and responsibilities of families/carers when taking patients on escorted leave and an information sheet be given to them and this procedure implemented Trust wide.

8.27 We agree with this recommendation. Mr D's family were not involved in consideration of what roles they would be expected to play when he was on leave. We do question the provision of an information sheet as a solution however and suggest that the policy expectation should be that there is a collaborative approach to family escorts when Section 17 leave is being arranged and agreed. This process should explicitly include feedback from the family on how leave has gone, and any associated problems or risk issues.

8.28 Recommendation 3. That when service users are an inpatient for three months and there is considered to be no or little improvement in their presentation, a suitable peer group is identified to undertake MDT peer review. Given the location of this unit consideration should be given to this being undertaken virtually.

8.29 We consider that this peer preview process could provide support with review, decision-making and future planning.

8.30 Recommendation 4. That there is a facilitated feedback session of this investigation report to support individual and team reflection and learning.

8.31 As always it is essential that learning from incidents is provided to clinicians involved, and we support this intention.

[90] *Root cause analysis - using five whys.* http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

8.32 Recommendation 5. The organisation to develop and implement a Sexual Safety Policy.

8.33 It was clear from the internal investigation, and from our review, that there was a lack of a proactive approach to inpatient sexual safety, and an insufficient response when there were allegations of sexual harassment and assault. We agree that a policy is necessary and suggest it should include reference to meeting the expected standards of single sex accommodation.[91]

8.34 The report highlights the good practice by the EIP Care Coordinator in being proactive, forming good relationships with his parents, and representing their views when appropriate. They also took positive steps to ensure that the out-of-area hospital was aware of the both the CCO and the family's concerns about discharge.

8.35 A further example of good practice was given that the member of the community team who also worked on Dova Unit was able to provide escorted leave as part of his role facilitating continuity between inpatient and community services.

8.36 In our view there were two significant areas of omission in the investigation:

- Failure to explore the decision-making process that resulted in Mr D being sent to a Psychiatric Intensive Care Unit (PICU) without assessment.
- A lack of exploration of the systems/processes in place for monitoring the care and treatment of patients placed in out-of-area beds, and how plans were developed to return patients to a Trust bed.

8.37 Both of these issues had a significant impact on the decision-making that resulted in Mr D being sent to Cygnet Health Care in Kent, and in his return without adequate planning. In the interview with the LCSFT Head of Safety, it was reported that several efforts had been made to contact people who had been involved in decision making but had been unsuccessful.

Action plan progress

"Review the progress that the Trust has made in implementing the action plan associated with their internal investigation".

8.38 The actions were all to be completed by November 2020. We have not been provided with any information about implementation of the action plan, and cannot fulfil this element of the terms of reference.

[91] *Delivering same-sex accommodation September 2019.* https://improvement.nhs.uk/documents/6005/Delivering_same_sex_accommodation_sep2019.pdf

Analysis of Cygnet Health Care internal investigation

8.39 The Cygnet internal investigation was carried out by a consultant forensic psychiatrist supported by a governance manager. Both had skills and experience in conducting investigations.

8.40 The investigation was not completed within 60 days. The final report was signed off by the investigators on 15 November 2019 but was not signed off by the relevant committee in Cygnet until 5 May 2020. Our review received the report in June 2020.

8.41 The report does not describe the investigation sufficiently. The chronology is brief and as a result the reader is not able to form an opinion on how the analysis and recommendations flow from the available evidence.

8.42 The methodology for the investigation is outlined in the report. However, it does not provide details of the staff interviewed and the investigation did not examine all the policies relating to Mr D's care, treatment and discharge. It identifies that it reviewed the Ward Operational Policy.

8.43 We would have expected the investigation to have reviewed all policies and procedures relating to care planning and treatment, risk assessment and management, the Mental Health Act, discharge, bed management, Being Open and Duty of Candour.

8.44 If available, we would have expected the investigation to have reviewed the policies/procedures relating to communication with families and host Trusts.

8.45 While the terms of reference for the investigation required it to consider appropriate communication with family members and provide them with the opportunity to contribute to the investigation, there was no contact between Cygnet Health Care and Mr D's mother or his father's wider family during the course of the investigation.

8.46 We are aware that there may have been barriers to communication with Mr D's mother because of the ongoing police investigation into the incident. However, we would have expected to have seen evidence of the organisation meeting the requirements of Duty of Candour. Furthermore, we would have expected to see evidence of ongoing liaison between Cygnet Health Care and the police so that Cygnet could contact Mr D's mother.

8.47 The report makes assumptions about the lack of liaison between Cygnet Health Care and Mr D's family, without seeking their opinion.

8.48 We were told that Mr D's father had been identified as next of kin, and this was interpreted as meaning that his mother should not be contacted. It is irrelevant who was named as his next of kin, Duty of Candour also applied to his mother.

8.49 Furthermore, it would have been good practice for the investigation to seek out contact details for the family of Mr D's father and seek their views on his care and treatment. In not doing this the investigation missed an opportunity

to gather information about his father's view of Mr D's care and treatment through the eyes of the wider family.

8.50 The report does not identify any contributory factors. There is an opportunity to do this in the table identifying the care and service delivery problems, but this section of the table is incomplete.

8.51 The section of the report that is titled 'Root Cause' contains a narrative and does not identify a root cause. In fact, it proposes that mental illness may not have played a role in the incident. There is an obvious incongruence within the statement, "the contribution of mental illness to the incident is not clear and may be explored further in the cause of the judicial proceedings that [Mr D] faces".

8.52 However, it does go on to explore the role that poor discharge planning may have had on the likelihood of the incident.

8.53 The terms of reference for the investigation have not been met, in these particular aspects:

- There was no contact with Mr D's mother or his father's family.
- There are no details provided about Cygnet Health Care meeting the requirements of the Duty of Candour immediately after the incident.
- The chronology in the report does not provide any detail about the care plans completed while Mr D was detained to Cygnet Health Care. The effectiveness of care plans and the involvement of Mr D and his family in care planning is not explored in the analysis section of the report.
- The chronology in the report does not provide any detail about the risk assessments completed while Mr D was detained to Cygnet Health Care. The care and service delivery section of the report identifies issues with the START risk assessment. It also identifies that different members of the care team had different views on his risk. It is not possible for the reader to establish how this conclusion has been reached because of the limited chronology. Furthermore, the analysis identifies that his, "episode of admission to Bearsted Ward was characterised by an absence of clinical incidents." Our review of the clinical records identified incidents that should have caused the clinical team concern based on Mr D's history.
- The analysis of risk assessment and management concentrates on the Multi-Agency Risk Evaluation (MARE) completed by the Care Coordinator (CCO) and Mr D's home Trust, and his engagement with the psychological interventions offered to him while he was on the ward. We would have expected to see details and a critique of the START risk assessment and review completed.
- The report does not contain a critical evaluation of the skills and knowledge of staff regarding risk assessment or environmental checks. There is no review of risk management training provision.

- The report makes no reference to having assessed Mr D's care, treatment or risk management against any Cygnet Health Care or national policies.
- The report identifies good practice following the incident, the completion of a 72-hour report and the immediate implementation of changes. However, the report does not provide any detail about the 72-hour report. We would have expected to have seen some detail about the 72-hour report and the changes which had been made to support the assertion that there was good practice.
- The report does not consider if the incident was predictable or preventable.

8.54 The report does not adequately examine what happened and why it happened. As a result, not all the issues with Mr D's care and discharge are identified. The impact of the recommendations will therefore have limited impact on the prevention of a recurrence of a serious incident.

8.55 The report contains three summary recommendations to address the care and delivery problems identified. These are not written in a SMART format. Recommendations should clearly define the outcome that is required to rectify the identified issue.

8.56 The recommendations are not numbered but are grouped under the headings of Mental Health Act (MHA), discharge planning and risk assessment.

8.57 Recommendation – Mental Health Act:

- MHA Section start and expiry dates should be scrutinised by a senior MHA administrator and/or a Consultant Psychiatrist.
- Consider making the MHA Office spreadsheet/tracker available to appropriate others in the hospital, such as via read-only access on the shared drive.

8.58 These recommendations are intended to address the recording error regarding the MHA section expiry dates. In our view there should be more robust action to minimise the risk of mistakes, and the recommendation is weakened by the use of the word "consider".

8.59 Recommendation – Discharge planning:

- Wherever possible, a Discharge CPA / Section 117 meeting should be held prior to discharge, to formulate a coordinated and integrated plan in a multi-agency manner, together with relevant community services and carers.
- There should be liaison and discharge planning with those who will be caring for or living with the patient after discharge, such as family/carers.
- Contact with external parties (family, carers, community team) should be documented in the clinical records (Pink Notes).

- Consideration should be given to measures to help manage potential risk more assertively in the community, such as:
  - Overnight Section 17 leave from the ward prior to discharge.
  - Suitability of a Community Treatment Order (Supervised Community Treatment).
  - Administration of medication by intramuscular depot where there is a risk of non-compliance in the community.
  - Confirmation of arrangements for forensic psychiatry assessment.
- The Discharge Notification prepared at discharge should include:
  - Name and contact details of key community professionals (e.g. community team, Care Coordinator, Community Consultant Psychiatrist, GP).
  - Plans for care after discharge including follow-up appointments.
  - Information on key risks and risk management.
  - Contingency plans.

8.60 While these may well be reasonable suggestions, many of them are existing policy expectations, which are already in place. To evidence change in practice we would expect to see some mechanism to provide assurance that these policy expectations and standards are met.

8.61 Recommendation – Risk assessment:

- Risk assessment should include and consider known historical risk incidents.
- There should be consistency and coherence across risk assessments, and explanations given when this is not the case.
- Risk assessments should include a written formulation of risk.
- Risk of disengagement from services should be considered in risk assessment, such as a Case Specific item in the START, as should potential of masking more significant symptoms.

8.62 All of these are essential aspects of risk assessment and should already be in place. There has been no exploration of the reasons why the risk assessment was inadequate.

8.63 The root cause section of the report contains a narrative and does not identify a root cause. In fact, it proposes that mental illness may not have played a role in the incident.

8.64 However, it does go on to explore the role that poor discharge planning may have had on the likelihood of the incident.

Finding 22 – Serious incident review

Neither the NHS Trust or the Cygnet internal investigation internal investigation met expected standards.

Best practice would have been a joint review completed in a collaborative manner by both Cygnet Health Care and the Trust.

Recommendation 16

The Trust must ensure that serious incident investigations are carried out at the appropriate levels, within expected timescales and that they provide evidence of action plan implementation.

Recommendation 17

Cygnet Health Care must ensure that serious incident investigations are carried out at the appropriate levels, within expected timescales and that they meet expected NHS England national standards.

Action taken by Cygnet since the incident

8.65 During interviews with the Cygnet staff, they were able to describe changes made since Mr D's discharge to mitigate against the issues identified occurring again.

8.66 A patient's Section papers are subject to scrutiny a minimum of three times and are signed off by the MHA lead, the Operations Manager and the Hospital Manager. Evidence of each is logged on a spreadsheet. The scrutiny checklist has a highlighted box for the expiry date to ensure it is visible. There are also monthly audits of Section paperwork in addition to corporate audits.

8.67 They have developed a Legal Status Spreadsheet. On this is recorded all of the details relating to detained patients, including the review date for the Sections. This is shared with three staff in the MHA office for scrutiny. In addition, there are monthly spot checks of the spreadsheet.

8.68 The role of Social Worker Assistant has been introduced on the ward. Their role is to support communication with the host care team and patient families. They are also responsible for ensuring that Section 117 responsibilities are considered and that all patients have a discharge CPA review meeting.

8.69 Teleconferencing has been introduced to the ward to allow host care teams and patients families to make a contribution to weekly ward rounds.

8.70 The record keeping on the ward has changed. The template for the ward round minutes has been revised and refreshed. They now include risk formulation and the ward consultant makes their own direct entry, not relying on the minute taker.

8.71 The ward has revised and refreshed how they do handovers. They have a daily board round every morning when the multidisciplinary team (MDT) reviews all the allocated tasks for the team. This includes a section on discharge planning. Every afternoon the MDT has a Safety Huddle to review how the shift is going that day and to discuss incidents and concerns.

8.72 The Responsible Clinician (RC) was able to describe a revised process for discharging a patient directly into a community setting. They take responsibility for these types of discharge. They liaise directly with the host care team and agree a discharge plan in place. This includes a risk management plan and any safeguarding concerns. In the 15 months since Mr D's discharge there have only been two discharges from Bearsted Ward directly into the community.

8.73 We were told that there is a quality assurance process in place for all discharge notifications from the ward. Patients being transferred to another PICU or stepped down to an acute ward have a discharge notification completed by the ward doctor which is quality assured by the ward consultant. For patients being discharged into the community the discharge notification is completed by the ward consultant and quality assured by the Medical Director.

8.74 The ward also has a process for managing discharges that includes making contact with the 'Nearest Relative'/next of kin.

8.75 The Cygnet Health Care Group have additionally revised and refreshed a wide range of their policies since the incident including Mental Health Act, Family and Carer Involvement, Individual Risk Assessment and Management, and the Discharge from PICU Protocol.

8.76 Following our interview with the lead author, contact was made by Cygnet with both Mr D's mother and his father's family. An apology for the lack of contact was given, and the lead author offered to meet to feedback on the report and take comments.

8.77 Family comments were subsequently provided to Cygnet, but it is unclear whether these have been incorporated into a further version of the report.

Finding 23 – Cygnet Health Care
Cygnet Health Care Maidstone did not have systems in place to ensure policies were followed.

Recommendation 18

Cygnet Health Care policies should clearly demonstrate the sign off and governance process.

Recommendation 19

Cygnet Health Care must demonstrate and provide assurance to commissioners that their admission, discharge and Care Programme Approach (CPA) policies are adhered to.

9. Domestic Homicide Review specific terms of reference

9.1 The focus of this section of the report is on the following overarching section of the terms of reference:

"Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims".

Specific terms of reference

9.2 To structure our analysis, we have discussed the issues under the following headings:

- Inter-agency information sharing and communication.
- Domestic abuse.
- Domestic abuse local strategy.
- Parricide.

Inter-agency information sharing and communication

9.3 The agencies relevant to this section of the review are:

- Cumbria Constabulary.
- Lancashire & South Cumbria NHS Foundation Trust.
- Cumbria County Council.
- NHS Morecambe Bay CCG.
- Two Barrow GP practices: Abbey Road Surgery, and Risedale Surgery.

9.4 We reference the material discussed in the agency sections above, using the detailed terms of reference below to guide our analysis:

"Identify any issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and perpetrator and to work effectively with other agencies.

Was information sharing within and between agencies appropriate, timely and effective?

Were there effective and appropriate arrangements in place for the escalation of concerns and how were these shared?

Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement".

9.5 There are two clear routes within and between the above services that provide a framework for multi-agency communication, particularly about risk: safeguarding structures and the MAPPA/MARE framework. We have commented on these and on learning identified in previous reports.

Safeguarding/adults at risk

9.6 As discussed in the safeguarding section above we have concluded that there were missed opportunities in relation to adult safeguarding. This relates to the expected statutory functions for potential 'adults at risk'.

9.7 The Care Act 2014 defines an adult at risk as someone over the age of 18 who:

- has needs for care and support (whether or not the local authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

9.8 There is no evidence to suggest that Mr M should have been considered as an 'adult at risk' in accordance with the Care Act 2014 (see safeguarding section). However, there were missed opportunities to consider safeguarding referrals for parents, grandparents and for a young member of the family. Even if Mr D was considered not to have care and support needs, the local authority may consider under section 14.44 statutory support guidance, to undertake a non-statutory enquiry if it promotes the wellbeing of the person and supports the preventative agenda.

MAPPA/MARE structures

9.9 The Multi-Agency Policy (MAPPA) indicates that the identification of a Multi-Agency Risk Evaluation (MARE) case is based on the judgement of the clinical/care team that the service user represents a high risk of serious harm to others, and the risk is current (that is, it is not a theoretical risk in the long term). Serious harm is defined as "an event which is life threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible".[92]

9.10 The policy advises clinical staff that when deciding to refer a service user into the MARE process the following points should be considered before making the referral:

- Evidence of increasing risk and/or patterns of behaviour (e.g. the use or presence of weapons etc.) and/or a known victim (named) as 'at risk'.

[92] *MAPPA Guidance 2012 Version 4, Section 11.7.* https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

- Offending behaviour linked to dangerousness and/or increased contact with the police (e.g. threats, possession of weapons, assault, sexual offending etc).
- Regular reporting of dangerous incidents from the community.
- History of non-compliance with treatment/services and/or difficulty in engaging service users leading to increasing dangerousness.
- Child Protection issues.
- Hospital Orders (e.g. Sections 37, 37/41, 47, 48, 45a Mental Health Act 1983 (as amended 2007) moving into the local community.
- Restraining or injunction orders involving staff, other service users, partners, or Trust property.
- Adverse incidents involving dangerous behaviour.
- Ex high secure, regional secure and low secure service users new to services from prison with knowledge of index offence of dangerousness.

9.11 The criteria were clearly met, and the policy expectation is that the clinical team should make the assessment and referral into the MARE process, and in this instance the referral came from Early Intervention in Psychosis pathway (EIP) as expected.

9.12 Overall, there was clearly good information sharing and action planning around Mr D, however the safeguarding actions around family members were presented as something to consider, when actual risk was already known and disclosed. Family were communicating and seem to have been very open with the care team, but these worker's priorities were Mr D, not the family. The family may not wish to fully disclose for fear of it being fed back to the perpetrator which increases risk, and may contribute to a feeling that they are seen as "locking him up".

9.13 This could impact what the family feel they could disclose in the future if previous disclosures negatively impacted the relationship and did not make them feel safer. Family needed an independent advocate to disclose to who could help them with options and safety planning around risk. If a worker had been involved, they may have picked up on escalation leading up to the event, triggering multi-agency involvement to de-escalate.

Multi-agency learning from previous reports

9.14 West Cumbria CSP published a Domestic Homicide Review (DHR) in 2015.[93] We reference this because there are recommendations made about several areas that have arisen in the course of this review:

- GP awareness and enquiry about possible domestic abuse.

[93] *Domestic Homicide Review West Cumbria Community Safety Partnership.* https://www.copeland.gov.uk/sites/default/files/attachments/dhr_overview_final_2015.pdf

- Cumbria Partnership Mental Health Trust review of the risk assessment tool, policies and procedures.
- Police officers should record any comments made by a vulnerable adult that could be considered threatening to any third party or be significant in any other way. These comments should be included in the Vulnerable Adult (VA) Report.

9.15 We have not reviewed this action plan but have discussed oversight of the action plan with the relevant Cumbria County Council department. We were informed that this would be the responsibility of the relevant Community Safety Partnership (CSP). There is a joint protocol with the three CSPs (Allerdale, South Lakeland, North Cumbria), but no countywide coordination of oversight of actions.

9.16 In our view these issues remain directly relevant to our findings in this case.

NHS out-of-area PICU mental health treatment

9.17 When patients are transferred to an out-of-area Psychiatric Intensive Care Unit (PICU) mental health service, we found there is a lack of oversight of the quality of care provided. There are no agreed national structures which clarify responsibility, accountability and information sharing.

9.18 We asked NHS Morecambe Bay CCG for their structures for quality monitoring of care in distant services. This is particularly relevant when a bed has been agreed in an unplanned way, which is often the case in PICU services.

9.19 We were told it is expected that within local geographical areas there should be commissioning intelligence on the contracts and quality of provision. There was no further detail provided.

Finding 24 – Inter-agency information sharing

The existing frameworks for information sharing and management of risk were utilised.

The local MAPPA/MARE Policy is overdue for review.

Safer Cumbria does not have a structure for the oversight of actions from domestic homicide reviews.

There is a lack of oversight of the quality of care in NHS PICU out-of-area treatment placements.

Recommendation 20

NHS England should gain assurance about the quality of private PICU provision following the principles of host commissioning arrangements. This is to ensure that the local CCG/ICS monitors and has quality oversight for providers in their locality. Quality issues should be raised via the quality system oversight groups.

Recommendation 21

Safer Cumbria and the local Community Safety Partnership should develop systems to ensure there is oversight of the implementation of action plans from domestic homicide reviews.

Domestic abuse

9.20 This section explores any awareness of domestic abuse within the family, whether this was known to any agencies, and how it may have been acted on.

9.21 The detailed terms of reference are below:

"Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies.

Explore whether the victim's family had any knowledge of domestic violence by the service user, if so, how was this knowledge acted upon?

Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies".

9.22 Information about previous risk within the family was reported to police and well documented.

9.23 However, the family did not see these behaviours as evidence of risks of domestic abuse or violence towards Mr D's father. This is a learning point for agencies, in that Intimate Partner Violence (IPV) is seen as the only form of domestic abuse. Adult Family Violence (AFV) is part of domestic abuse, as enshrined in the definition.

9.24 The risks identified were acted upon as part of the treatment of Mr D, however there was no recognition that Mr M or Mr D's mother may be at risk of domestic abuse, with no signposting or referrals. Front line workers did not have the knowledge to identify AFV as domestic abuse and risk assess and support as a result. This, alongside community awareness, points to the inability of police, GPs and mental health services to recognise AFV risks, and suggests a training need.

Finding 25 - Domestic abuse

The Trust did not give sufficient consideration to the potential risk to Mr M following the hostility that Mr D presented while an inpatient.

Recommendation 22

The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members.

Domestic abuse local strategy

9.25 We have accessed the Safer Cumbria Domestic Abuse Strategy,[94] and have been given information about how this has been operationalised. We were told that each partner organisation is responsible for the development of local protocols and the training of their staff. There is no central budget to support this.

9.26 We were informed that the 2018 strategy was not translated into a formal action plan, and the current structures are undergoing changes. Within the strategy there is no mention of risk to parents from adult children.

9.27 There has been a revision of structures for the management of community safety, and the 'Safer Cumbria' partnership is now responsible for the domestic abuse strategy.

Finding 26 – Domestic abuse local strategy

There is a high level strategy for community safety , which includes the approach to domestic abuse.

Recommendation 23

Safer Cumbria must develop and implement a comprehensive domestic abuse action plan which includes the learning from this review.

Parricide

9.28 In this section we offer a perspective on the particular aspect of parricide, tragically illustrated in this homicide, in accordance with the terms of reference below:

"Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office".

[94] *Cumbria Domestic Abuse Strategy, 2018 – 2020.*

9.29 Patricide is defined as the killing of a father by their son/daughter and matricide the killing of a mother by their son/daughter. Parricide is defined as the killing of a parent by a child of any age. This could include biological parents, step-parents or adoptive parents.

9.30 A review of parricide undertaken as part of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness identified two types of parricide offences from their review of the literature. These are offences committed by adolescents and those committed by adults. In the latter group, they found that the perpetrators were either mentally ill, particularly with psychosis, or there were factors of antisocial behaviour/violent personalities. They also noted that schizophrenia was the most common diagnosis.

Parricide and mental disorder

9.31 The rates of mental disorder in parricide offenders varies according to the population studied. For example, in a Canadian study (Bourget et al. 2007), only 8% of matricide perpetrators and 6% of patricide perpetrators were found not to have a mental disorder. In that sample, two-thirds of the male parricide offenders were motivated by delusional thinking. This reflects other studies; for example, in a study from the USA, four factors were identified which were significant in parricide offences. These were:

- Acute psychosis – 47%
- Impulsivity – 28%
- Alcohol and substance misuse – 24%
- Escape from enmeshment[95]– 15%

9.32 In another large study from a high secure hospital in England (Baxter et al. 2001),[96] consecutive admissions over a 25-year period were studied and 98 admissions over that period were identified who had committed parricide offences, of whom six were double parricides. The study compared this group with a group of patients who had killed strangers. It was found that the group committing parricide offences had a higher proportion of patients with schizophrenia compared to the other group where the most common diagnosis was of personality disorder.

9.33 The study also found that the parricide group were less likely to have a criminal history, but there was a higher incidence of previous attacks on the victim. One important factor that was noted was that the parents may have placed themselves at risk by being more tolerant of violence and seeing it as an inevitable consequence of their son or daughter's schizophrenic illness.

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[95] *Enmeshment is a psychological term that describes a blurring of boundaries between people, typically family members. Salvador Minuchin. (2005). Contemporary Authors Online. Retrieved from http://www.gale.cengage.com/InContext/bio.htm*

[96] *Baxter, H., Duggan, C., Larkin, E., Cordess, C., and Page, K. (2001) mentally disordered parricide and stranger killers admitted to high security care. The Journal of Forensic Psychiatry. 12, 287 – 299.*

9.34 In another study undertaken as part of the National Confidential Inquiry (Rodway et al. 2009)[97] which was not specifically focussed on parricide, the methods of homicide compared by diagnostic group were studied. It was found that just over half of all perpetrators with schizophrenia had killed a family member or current/former spouse. They found that the majority had active symptoms at the time of their offence, mostly delusions and/or hallucinations; of these, over two-thirds reported experiencing delusions specifically related to their victim. The study found that of all homicide offenders with severe mental illness, half also had a comorbid alcohol and/or drug dependence/misuse problem. It was also found that these patients were more likely to use a sharp instrument in the homicide and the study therefore highlighted the importance of enquiring into the carrying of weapons by patients with schizophrenia.

9.35 Of the parents killed by sons, 53% killed their father and 47% killed their mother, showing that the gender of victims was evenly distributed. However, the age of the parent varies by gender; most men are killed by their offspring when in their 50s and most women are killed by their offspring when in their 70s.

9.36 However, the authors note that the nature of motherhood and fatherhood, and therefore the nature of the parental relationship, changes throughout the lifecycle. This means that mothers and fathers are most at risk from parricide at different ages, and from different identified 'circumstances'. These circumstances will be shaped by different events, concerns and pressures, depending on where in the lifecycle the family members are located.

9.37 A literature review of the use of kitchen knives in homicides (Hughes et al. 2012)[98] by mentally disordered offenders showed that the most frequent method of causing death in parricides is use of a sharp or blunt instrument (60%), a method that is more frequently used than in general homicides (43%) (ONS, 2014).

9.38 The study showed that kitchen knives are used more often than other types of knife amongst perpetrators of homicide in England who have had contact with mental health services. While this study did not show any significant relationship between having schizophrenia and the use of kitchen knives, it was shown that most homicides in this study where kitchen knives were used were unplanned.

9.39 In the first national analysis of parricide using the Home Office Homicide Index for England and Wales (Holt 2017),[99] all recorded cases of parricide over a complete 36-year period (January 1977–December 2012) were identified.

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[97] Rodway, C., Flynn, S., Swinson, N., Roscoe, A., Hunt, I. M., Windfur, K., Kapur, N., Appleby, L., and Shaw, J. (2009) Methods of homicide in England and Wales: a comparison by diagnostic group. The Journal of Forensic Psychiatry & Psychology. 20, 286 – 305.

[98] Hughes, N.H.S., Macaulay A.M., Crichton J.H.M. (2012) Kitchen knives and homicide by mentally disordered offenders: a systematic analysis of homicide inquiries in England 1994–2010. The Journal of Forensic Psychiatry & Psychology. Vol. 23, Nos. 5–6, October–December 2012, 559–570.

[99] Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents, and outcomes. Criminology & Criminal Justice.

There were 693 incidents of parricide recorded in England and Wales, suggesting a mean of approximately 19 incidents per year. There were 716 victims in total over this period. Despite the general downward trend in homicides that has been observed since 2002/03 across England and Wales, including domestic homicides, the rate of parricides has remained stable, at approximately 0.04 victims per 100,000 population per year. The study found that 35% of offenders were intoxicated at the time of the killing(s). For offenders, this is almost double the proportion found in all homicides in England and Wales.

9.40 The Homicide Index includes a category of an 'irrational act' for the killing(s). In the parricide cases with this category, it was more frequently used as the main circumstance with female victims (35%) compared with male victims (14%); this difference was statistically significant. Additionally, the use of diminished responsibility as a partial defence constituted 24% of homicide convictions in parricide cases, but only 5.5% of overall homicide conviction outcomes. Only 44% of parricide offenders were detained in prison (or its equivalent in the case of juveniles). This compares with the 94% of all homicide offenders who are detained in prison. Furthermore, while 62% of all homicide offenders received a sentence of life imprisonment, only 38% of parricide offenders received this sentence.

9.41 Hospital Orders were widely used in parricide cases, again much more so when compared with homicide cases generally (31% vs. 6%). While the findings presented in this study do support the idea that mental illness plays an important role in the perpetration of parricide, the author was clear to point out that this study still suggests that most parricides are not the product of mental illness.

Implications for risk management

9.42 It could be argued from reviewing the literature on parricide and then comparing it with the broader work on homicide committed by mentally disordered offenders, that there may not be anything particularly different about those offenders who kill their parents compared to those who kill other family members. In fact, there have been a number of recent high-profile cases where a parent and sibling or other family member was killed at the same time. As parricide is so rare, it is probably not possible to distinguish this group from the rest of the mentally disordered offenders who kill a family member.

9.43 However, we wish to highlight three important factors:

- The importance of active symptoms of mental illness at the time of the offences. This is particularly true when these are delusions relating to family members. In turn, this then emphasises the importance of optimum clinical management of patients, particularly ensuring assertive treatment, including compliance with antipsychotic medication.

- Comorbidity of mental illness with alcohol and/or drug use. This has long been recognised as a very significant factor in increasing the risk of violence towards others in patients with schizophrenia.
- Effective liaison with the family, not only to obtain information related to risk but also to offer illness education for the family and highlight the importance of compliance with medication for their family member. This was also highlighted by the National Confidential Inquiry who recommended that services should explore the relationship between family members and specifically enquire about previous violence and delusional beliefs relating to family members.

9.44 Finally, at least one of these studies (Byoung-Hoon Ahn et al. 2012)[100] raise the issue of increasing risk of harm to parents who actively seek to promote treatment compliance in their children or who may be actively involved in their involuntary admission to hospital. This is particularly relevant to their role as the 'nearest relative' under the Mental Health Act (MHA), where their consent is required for admission under Section 3.

9.45 In this case, in March 2019 the First-tier Tribunal upheld Mr D's detention under Section 3 MHA. During the Tribunal some of the information that the family had shared in confidence with mental health professionals was shared with Mr D.

9.46 The decision to share this information was made by the Tribunal Panel. His family were very angry about this disclosure. His father thought that this would put further pressure on already strained family relationships and could put them at risk of harm from Mr D when he was unwell. His mother was concerned that his leave might be reinstated.

9.47 Mr D's subsequent hostility to his father is clearly documented. The family became concerned that subsequent disclosures may also be shared with Mr D, which caused them to be more circumspect in what they shared with professionals about Mr D's care.

9.48 We consider that the First-tier Tribunal should clarify how third-party information, such as from families, will be used in a formal Tribunal.

[100] *Byoung-Hoon Ahn, Jeong-Hyun Kim, Sohee Oh, Sang Sub Choi, Sung Ho Ahn and Sun Bum Kim. (2012) Clinical features of parricide in patients with schizophrenia. Australian & New Zealand Journal of Psychiatry, 46, 621 – 629.*

Finding 27 – Parricide

The understanding of potential risk of harm to parents was not incorporated into risk assessments by the Trust.

Mental illness and adult child-to-parent violence should be incorporated into domestic abuse strategies.

Recommendation 24

The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy and procedures.

Recommendation 25

NHS England should share learning identified about parricide with the Home Office.

Recommendation 26

NHS England should share the learning with the First Tier Tribunal (Mental Health) about parricide and risk to family members, and how sensitive third-party information is managed.

10. Lessons identified

Summary

"Identify any gaps in collaboration and provision of health, social care and housing support services.

Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office".

10.1 Mr M was a well-loved member of the family, and a respected member of the community. He was a private man but had always strived to ensure his son was looked after.

10.2 There is considerable evidence to suggest that Mr D had been experiencing challenges with his mental health since 2014, and possibly for some time before this. This evidence can be found in the information that his parents shared with services and in the assessment completed at the beginning of his treatment by Early Intervention in Psychosis pathway (EIP). It is possible that as a result his psychosis was less responsive to treatment.

10.3 It is well documented that Mr D was an intelligent young man, who was adept at both masking and rationalising the symptoms of his psychosis. Professionals working with Mr D needed to spend long enough with him to allow him to drop his guard and expose his psychosis.

10.4 Mr D was under the care of the Mental Health In-Reach Team (MHIT) while detained to HMP Prison in 2017/18. There was a missed opportunity for care to continue in the community when the MHIT failed to send a discharge summary to his GP when he was released in March 2018. This would have alerted his GP to Mr D's emerging mental health issues and his need for assessment and treatment.

10.5 His GP was prompt in referring Mr D to mental health services when he presented for an appointment in June 2018. His GP allowed sufficient time at this appointment for Mr D's psychosis to emerge.

10.6 The community mental health services were swift in their response to the GP referral. Within a couple of weeks Mr D had been seen and treated by the Access and Liaison Integration Service (ALIS), accepted for care and treatment by EIP and allocated a Care Coordinator (CCO).

10.7 The care and treatment he received from EIP was of a high standard and in line with national good practice guidance for this service. They worked to develop a therapeutic relationship with him and his family. They were also responsive to his changing needs, arranging for Mental Health Act Assessments (MHAAs) when needed and treating him in the least restrictive

manner by engaging with the Home Treatment Team (HTT) and the team psychologist.

10.8 The CCO was equally proactive and responsive to Mr D's needs. They also engaged with his parents and were proactive and responsive in their relationship with them.

10.9 While detained to both Hadrian Unit and Dova Unit, Mr D was provided with regular one-to-one sessions with nursing staff, was seen weekly by his Responsible Clinician (RC) and had care and risk plans. However, we have made recommendations about practice in relation to safeguarding and the management of risk.

10.10 Mr D was supported with leave from both wards. The arrangements for his leave changed regularly to reflect the concerns expressed by his family. However, his leave would have been more effectively managed by Dova Unit. Mental state assessments had been completed both before and after leave in line with the Trust Section 17 Leave Policy. However, we found that the decision-making about risk should have taken current risk information into consideration.

10.11 Both wards were mixed sex wards, and this resulted in Mr D's sexually disinhibited behaviour being a challenge to manage. The wards used the only options open to them: talking to Mr D about his behaviour, varying his observation levels and locking the doors to the female sections of the ward. The care and treatment provided at the Hadrian Unit was appropriate although it was a challenge to manage his sexually disinhibited behaviour on a mixed sex ward.

10.12 While Mr D was on Hadrian Unit he was established on medication. The care team were mindful that there had been concerns about Mr D not taking his medication, to support his compliance he was provided with orodispersible medication.

10.13 There was a period of time while Mr D was on Dova Unit (February to April 2018) when Mr D was prescribed medication in tablet form. During his time his parents raised concerns that they believed he was not taking his medication and that his condition was not improving. The ward's initial response to his parents' concerns about non-compliance with medication was to put a note on his medication chart to ask staff dispensing medication to be more vigilant to the risk of Mr D secreting the medication. This allowed the doubts about compliance to continue for another few weeks before his medication was changed to an orodispersible medication. February to April was a missed opportunity to establish Mr D on medication that may have improved his presentation.

10.14 Mr D was not making any progress on Dova Unit. The Ward and CCO demonstrated a proactive approach to his care by agreeing to make a referral to the rehabilitation ward. This was intended to develop a holistic assessment of Mr D's care needs and support a plan for his discharge into the community.

10.15 While regular risk assessments were completed while Mr D was under the care of the Trust, they did not fully explore his potential risk to family members and the GRiST assessment format does not explicitly ask staff to consider this risk to adult family members. It is possible that this lack of a prompt resulted in staff not documenting the family's concerns about Mr D's behaviour towards them.

10.16 There was nothing that could have alerted the Unit or Mr D's family to the risk of him going AWOL. He had always returned to the Unit from leave in the past, even if he returned late on a couple of occasions. Mr D told the staff at Bearsted Ward that he went AWOL from the ward because he was unhappy with the plan to transfer him to a rehabilitation ward. He believed that his CCO and the Dova Unit RC were colluding to keep him in hospital.

10.17 Dova Unit acted appropriately when Mr D went AWOL by notifying the police and senior management; they also maintained contact with Mr D's family while he was AWOL.

10.18 The plan put in place by senior management to transfer Mr D to a male Psychiatric Intensive Care Unit (PICU) when he was found after being AWOL lacked transparency. It was not discussed with the CCO or his family. He was transferred to Cygnet Kent without the Trust PICU completing a triage assessment and without a mental state assessment. No alternatives to a male PICU over 300 miles away from his home and supportive family were considered.

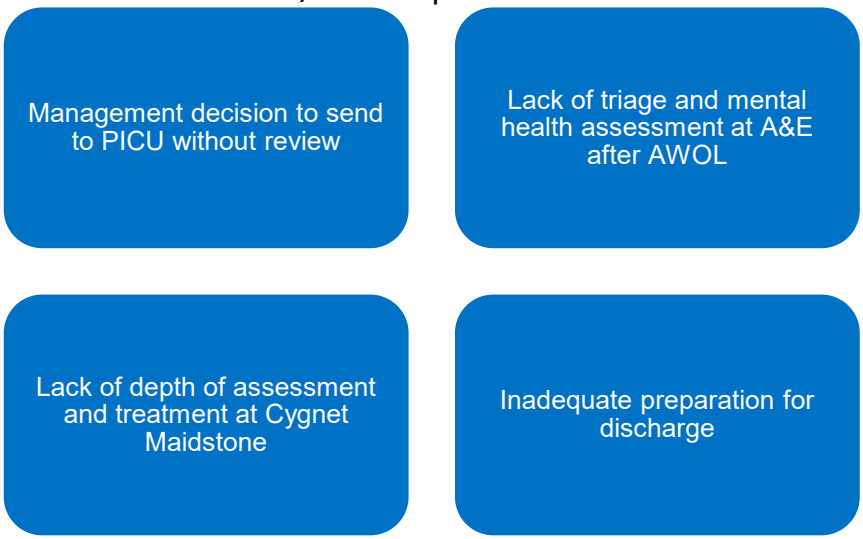
10.19 We have concluded that the overall standard of the care provided to Mr D by the Trust was good and met with Trust and national guidance.

10.20 Inter-agency communication regarding the management of risk through the Multi-Agency Risk Evaluation (MARE) process worked well.

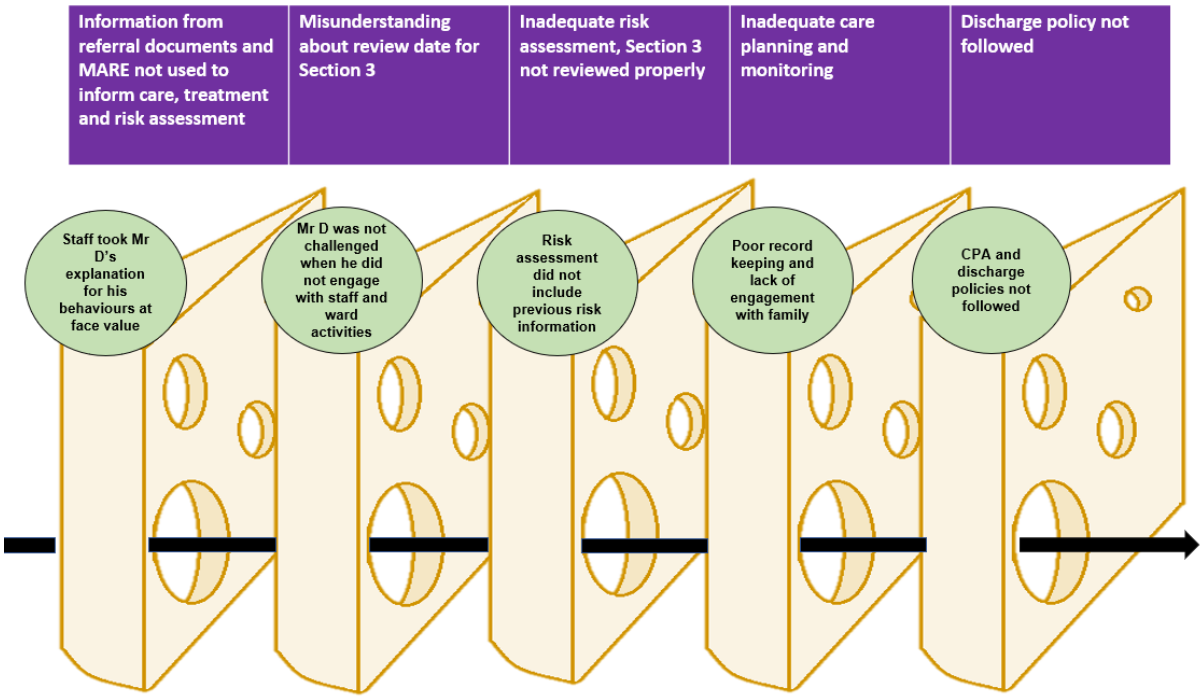
10.21 However, placing Mr D in a geographically distant PICU, without a clinical review and consultation, with a lack of quality and management oversight of the care and decision-making increased the risk that his care could become uncoordinated.

10.22 In our view the inadequate discharge from Cygnet Health Care can be identified as the significant service delivery issue that contributed to the homicide.

10.23 We have set out below the care and service delivery issues in relation to Mr D's care and treatment that may have impacted on the homicide of his father:



10.24 The diagram below illustrates the missed opportunities to manage risk safely during his stay at Cygnet Maidstone:



Good practice

"Identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from March 2018 to the incident occurring in June 2019".

The EIP CCO provided a continuity of care that ensured Mr D's care was of a consistently high quality until his transfer to Kent. Good communication and record keeping ensured that other agencies and notably his parents were involved and informed.

Appendix A – Terms of reference for the joint review

Terms of Reference for Independent Investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015.

The following Terms of Reference for Independent Investigation 2019/1764 have been drafted by NHS England North in consultation and with the agreement of West Cumbria Community Safety Partnership.

The terms of reference will be developed further in collaboration with the offeror and affected family members. However, requirements under Appendix 1 above and Domestic Homicides Reviews under the Domestic Violence, Crime and Victims Act published by the Home Office in 2016, are expected to be met for this case.

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To identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from March 2018 to the incident occurring in June 2019.

Involvement of the affected family members and the perpetrator**.**

- Ensure that the family is fully informed of the investigation and the investigative process and they understand how they can contribute to the process.
- Involve the affected family as fully as is considered appropriate, in liaison with Victim Support, police and other support organisations.
- Offer a meeting to the perpetrator so that he can contribute to the investigation process.
- Care and treatment
- In the absence of the internal investigation report, compile a detailed chronology of contacts and service access.
- Undertake a critical review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence – focussing on the period from March 2018 to the incident occurring in June 2019.
- Review the appropriateness of the treatment of the service user and the victim in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family. Comment on how the family's views and concerns were addressed.
- Consider the quality of both health and social care assessments on which decisions were based and actions were taken.

- Inter-agency working and communication
- Explore whether the victim's family had any knowledge of domestic violence by the service user, if so, how was this knowledge acted upon?
- Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon?
- Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims.
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to required service responses including changes to policies and procedures as appropriate.
- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement.
- Identify any issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and perpetrator and to work effectively with other agencies?
- Identify any gaps in collaboration and provision of health care, social care and housing support services.
- Identify whether information sharing, including communication in relation to discharge planning within and between agencies was appropriate, timely and effective?
- Were there effective and appropriate arrangements in place for the escalation of concerns and how were these shared?
- Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.
- Risk assessment
- Review the adequacy of risk assessments and risk management, including specifically the risk posed to others and how this was shared.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of Care Programme Approach (CPA) review.

- Consider whether either the victim or the perpetrator was a ‘vulnerable adult’.
- Review the Trust’s assessment of vulnerable carers, who are known to be caring for adults with mental health issues.
- Serious incident review
- Review the Trust post-incident internal investigations and assess the adequacy of their findings, recommendations and action plans.
- Review the progress that the Trust has made in implementing the action plan associated with their internal investigation.
- Deliverables
- Provide a final written report to NHS England and West Cumbria Community Safety Partnership (CSP) (that is easy to read and meets NHS England accessible information standards) within six months of receipt of all clinical and social care records.
- Based on investigative findings, make organisational specific outcome focussed recommendations with a priority rating and expected timescale for completion.
- Share the findings of the report in an agreed format, with the affected family and the perpetrator, seek their comments and ensure appropriate support is in place ahead of publication.
- Deliver an action planning event for the Trust and other key stakeholders to share the report’s findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to those with a legitimate interest.
- In consultation with NHS England, hold a learning event for involved practitioners and services to share the report’s findings and recommendations.
- Conduct an assurance follow-up visit with key stakeholders, in conjunction with the relevant CGG, 6 months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short-written report, for NHS England that will be shared with families and stakeholders and will be made public.

Appendix B – Documents reviewed

CPFT documents

- Internal investigation report
- Incident and Serious Incidents that Require Investigation (SIRI) Policy. May 2019.
- Care Programme Approach & Care Management Policy. August 2018.
- Safeguarding Adults at Risk Policy. January 2020.
- Clinical Risk Policy. February 2019.
- Delivering Same Sex Accommodation Declaration of Compliance 2020/21
- Domestic Abuse Policy
- Safeguarding Adults at Risk Policy
- Alcohol & Substance Misuse Policy
- Care Coordination Policy
- Clinical Risk Policy
- Health Records Policy
- Controlled Drugs Policy
- Incidents and Serious Incidents that Require Investigation Policy
- Information Sharing Policy
- Mental Health Act Policy & Guidelines
- Policy for the Management of Service Users Missing or Absent Without Official Leave
- Prevention and Management of Violence & Aggression Policy
- Protocol for the Management of Informal Patient's Leave from Adult Acute Mental Health In-patient Wards
- Transfer and Discharge of Patients within Mental Health and Learning Disability Services
- Multi-agency
- Joint Operational Protocol for Interagency Assistance – Mental Health
- Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy
- Mentally Disordered Offenders County Protocol

- Cygnet Health Care documents
- CPF 1 12 2 Discharge Checklist
- CPF 1.04 Care Programme Approach
- CPF 1.12 Transfer and Discharge Policy

- CPF 1.14 Management of Individuals' Records – care files and documentation
- CPF 2.18 Dual Diagnosis Policy
- CPF 3.01 Medication Management Policy
- CPF 3.02 Management of Suspected Illicit Substances on Cygnet Premises Policy
- CPF 4 Incident Reporting and Management Policy
- CPF 4.0.06 Duty of Candour Procedures
- CPF 4.15 Individual Risk Assessment and Management
- CPF 6.01.1 Family and Carer Involvement
- Discharge from PICU Protocol
- IG 08 Data Sharing Policy
- IG 11 Records Management and Data Quality Policy
- Local Medication Policy
- MHA 00.2 MHA Statement of guiding principles and introduction to various acts
- MHA 00.3 Part 1 Application of the Mental Health Act 1983
- MHA 00.4 Functions of Hospital Managers
- MHA 00.7 Code of Practice
- MHA 00.8 Policy for the administration of the Mental Health Act 1983
- MHA 09.01 Section 117 Aftercare
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- Other documents
- Individual Management Reports.
- Cumbria Domestic Abuse Strategy 2018 – 2020.
- Safer Cumbria Partnership 2020 – 2025.
- Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy. January 2017.
- Planning effective mental health care in prisons using the Care Programme Approach and the Community Mental Health Framework. Royal College of Psychiatrists (CCQI346). September 2020.

Appendix C – NIAF: internal investigations review

Lancashire & South Cumbria internal report

Rating	Description	Number
	Standards met	**12**
	Standards partially met	**4**
	Standards not met	**9**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident.	The report identifies that it is a root cause analysis investigation report in accordance with the NHS England Serious Incident Framework and is a Level 2 investigation.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	The terms of the reference were appropriate in terms of scope. They require the investigation to consider the overall leadership and management, and organisational systems and processes that underpinned the care and support provided. There were additional terms of reference provided by the family.	
1.3	The person leading the investigation has skills and training in investigations.	CPFT approached Lancashire Care NHS Foundation Trust and requested that they complete the investigation. In October 2019 Lancashire Care NHS Foundation Trust merged with the southern part of CPFT to become Lancashire and South Cumbria Care NHS Foundation Trust. The investigation was completed by the Head of Safety, Lancashire Care NHS Foundation Trust, who has the necessary skills and experience.	
1.4	Investigations are completed within 60 working days.	The investigation was not completed with the 60 days specified by the framework. The incident occurred on 19 June 2019 and we were provided with the final draft of the report on 28 August 2020. A number of reasons have been provided for the late delivery of the report: • The investigator was experiencing work pressures due to staffing issues • The impact of COVID-19 • The ongoing police investigation	

Standard		Niche commentary	
		• The time spent seeking to engage with Cygnet	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report that we were provided to review was in draft form and contained typographical errors.	
1.6	Staff have been supported following the incident.	The report does not contain any information about support provided to staff following the incident.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	There is a summary of the background to the incident.	
2.2	The terms of reference for the investigation should be included.	The terms of reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	The report describes that the internal investigation team met with the Care Coordinator, reviewed organisational clinical records and Trust policies. A root cause and contributory factors are set out. The investigator did not meet with staff who provided care and support to the patient across the whole of his care and treatment pathway with the Trust. We consider this to be a failing of the investigation. We would have expected to have seen interviews with all the staff responsible for Mr D while he was under the care of the ALIS, the Home Treatment Team (HTT), Hadrian Unit and Dova Unit.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	The report describes having contact with Mr D's mother in autumn of 2019, but no evidence was provided of ongoing contact with her or support for her. No contact was made with his father's family.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	Mr D's mother was given the opportunity to contribute to the investigation and provided questions that were added to the terms of reference for the investigation. His father's family were not given the opportunity to contribute to the investigation or outline any concerns that they may have had about his care or the support provided to his father by services. The patient was not approached.	
2.6	A summary of the patient's relevant history and the	A summary of the relevant history and process of care was included.	

Standard		Niche commentary	
	process of care should be included.		
2.7	A chronology or tabular timeline of the event is included.	A narrative chronology of care was included. This, at times, lacks detail and the report would have benefitted from a tabular timeline as an appendix.	
2.8	The report describes how Root Cause Analysis (RCA) tools have been used to arrive at the findings.	There is no description of how a root cause was established.	
2.9	Care and Service Delivery Problems (CDP & SDP) are identified (including whether what were identified were actually CDPs or SDPs).	No care and service delivery problems are explicitly identified.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	Contributory factors are identified.	
2.11	Root cause or root causes are described.	The investigation describes the root cause as, 'It is likely that the service user was not medicated at the time of his father's death given his belief that he was not ill and previous non-concordance with medication'. This statement does not describe a root cause because it is not supported by evidence and is supposition.	
2.12	Lessons learned are described.	Lessons learned are not described. The failure to describe a root cause has resulted in a missed opportunity to identify areas for learning.	
2.13	There should be no obvious areas of incongruence.	See root cause comment 2.11 above.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The report is not set out in a manner that supports the reader to identify how the terms of reference are met. The report does explore the care and treatment provided to the patient. However, it does not explore the overall leadership and management of care and treatment or the organisational systems/processes that underpin care and treatment in this case. For example, the investigation did not explore the systems/processes in place for monitoring the care and treatment of patients placed in out-of-area beds, and how plans were developed to return patients to a Trust bed.	

Standard		Niche commentary	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues.	With the exception of establishing what happened to the victim, the terms of reference covered the right issues.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	The report considers what factors contributed to poor care and the missed opportunities that suggest how a reoccurrence might be prevented.	
3.3	Recommendations relating to the findings and that lead to a change in practice are set out.	Five recommendations were made, all relate to the findings.	
3.4	Recommendations are written in full, so they can be read alone.	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome focussed.	Recommendations are measurable and outcome focussed.	

Cygnet internal report

Rating	Description	Number
	Standards met	**3**
	Standards partially met	**10**
	Standards not met	**12**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident.	The report does not identify the level of investigation. Reviewing the methodology and the final report we have concluded that a comprehensive investigation was completed.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation.	The investigation has terms of reference, but it is our opinion that there were aspects of Mr D's care that required investigation and were omitted from the terms of reference. These areas include: • Communication with the Care Coordinator and home Trust • Bed management processes.	
1.3	The person leading the investigation has skills and training in investigations.	The lead investigator was a consultant forensic psychiatrist supported by a governance manager. Both had skills and experience in conducting investigations.	
1.4	Investigations are completed within 60 working days.	The investigation was not completed within 60 days. The final report was signed off by the investigators on 15 November 2019 but was not signed off by the relevant committee in Cygnet until the 5 May 2020.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors).	The report does not describe the investigation sufficiently. The chronology is brief and as a result the reader is not able to form an opinion on how the analysis and recommendations flow from the available evidence.	
1.6	Staff have been supported following the incident.	The report does not identify how the staff were supported following notification of the incident.	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	There is a brief summary of the incident and the immediate outcome. The report does not contain any information about the legal outcome of the incident.	

Standard		Niche commentary	
2.2	The terms of reference for the investigation should be included.	The report includes terms of reference for the investigation.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	The methodology for the investigation is outlined in the report. However, it does not provide details of the staff interviewed and the investigation did not examine all the policies relating to care, treatment and discharge. It identifies that it reviewed the Ward Operational Policy. We would have expected the investigation to have reviewed all policies and procedures relating to care planning and treatment, risk assessment and management, the Mental Health Act, discharge, bed management, Being Open and Duty of Candour. If available, we would have expected the investigation to have reviewed the policies/procedures relating to communication with families and host Trusts.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	While the terms of reference for the investigation required it to consider appropriate communication with family members and provide them with the opportunity to contribute to the investigation, there was no contact between Cygnet Health Care and Mr D's mother or with his father's family during the course of the investigation.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	We are aware that there may have been barriers to communication with his mother in the early stages, because of the police investigation into the incident. However, we would have expected to have seen evidence of the organisation meeting the requirements of Duty of Candour. Furthermore, we would have expected to see evidence of ongoing liaison between Cygnet Health Care and the police so that Cygnet could contact his mother. The report makes presumptions about the lack of liaison between Cygnet Health Care and Mr D's family, without seeking their opinion. It is irrelevant who was named as his next of kin, Duty of Candour also applied to his mother. Furthermore, it would have been good practice for the investigation to seek out contact details for the family of his father and explore their views on his care and treatment. In not doing this the investigation missed an opportunity to gather information about his father's view of Mr	

Standard		Niche commentary	
		D's care and treatment through the eyes of the wider family.	
2.6	A summary of the patient's relevant history and the process of care should be included.	There is a summary of history and the process of care. However, this is brief and contains insufficient information about Mr D's mental health care and treatment. It is to be noted that the report provides greater detail about his offending history than it does about his mental health assessment, care and treatment. There is also a very short tabular timeline that covers his admission to Bearsted Ward.	
2.7	A chronology or tabular timeline of the event is included.	The report does not include a chronology or timeline for the event.	
2.8	The report describes how RCA tools have been used to arrive at the findings.	The report does not describe the RCA tools used to arrive at its findings.	
2.9	Care and Service Delivery problems (CDP & SDP) are identified (including whether what were identified were actually CDPs or SDPs).	The report contains a table that identifies care and service delivery problems. However, it does not identify which each problem is – care or service delivery.	
2.10	Contributory factors are identified (including whether they were contributory factors, use of classification frameworks, examination of human factors).	The report does not identify any contributory factors. There is an opportunity to do this in the table identifying the care and service delivery problems, but this section of the table is incomplete.	
2.11	Root cause or root causes are described.	The section of the report that is titled 'Root Cause' contains a narrative and does not identify a root cause. In fact, it proposes that mental illness may not have played a role in the incident. However, it does go on to explore the role that poor discharge planning may have had on the likelihood of the incident.	
2.12	Lessons learned are described.	Lessons learned are not described in the report.	
2.13	There should be no obvious areas of incongruence.	The report refers to remarks made by the judge as part of the trial.	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The terms of reference for this investigation have not been met: – There was no contact with Mr D's mother or his father's family. – There are no details provided about Cygnet Health Care meeting the	

Standard		Niche commentary
		requirements of the Duty of Candour immediately after the incident. – The chronology in the report does not provide any detail about the care plans completed while Mr D was detained to Cygnet Health Care. The effectiveness of care plans and the involvement of the patient and his family in care planning is not explored in the analysis section of the report. – The chronology in the report does not provide any detail about the risk assessments completed while Mr D was detained to Cygnet Health Care. The care and service delivery section of the report identifies issues with the START risk assessment. It also identifies that different members of the care team had different views on his risk. It is not possible for the reader to establish how this conclusion has been reached because of the limited chronology. Furthermore, the analysis identifies that his, "episode of admission to Bearsted Ward was characterised by an absence of clinical incidents". Our review of the clinical records identified incidents that should have caused the clinical team concern based on Mr D's history. The analysis of risk assessment and management concentrates on the MARE completed by the Care Coordinator and Mr D's home Trust, and his engagement with the psychological interventions offered to him while he was on the ward. We would have expected to see details and a critique of the START risk assessment and review completed. The report does not contain a critical evaluation of the skills and knowledge of staff regarding risk assessment or environmental checks. There is no review of risk management training provision. The report makes no reference to having assessed his care, treatment or risk management against any Cygnet Health Care or national policies. The report identifies good practice following the incident, the completion of a 72-hour report and the immediate implementation of changes. However, the report does not provide any detail

Standard		Niche commentary	
		about the 72-hour report. We would have expected to have seen some detail about this and the changes made to support the assertion that there was good practice. – The report does not consider if the incident was predictable or preventable.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues.	The terms of reference appear to be generic in nature. They would have benefit from including: • A reference about how the Cygnet Health Care clinical team included Mr D's Care Coordinator in the care and risk planning process. This would have helped Cygnet Health Care explore the wider issues of how they involve host Trusts in the care of patients who are admitted to their provision. • A reference about how the bed management process is managed at Cygnet Health Care. Mr D's host Trust had requested that an acute bed be found for Mr D within Cygnet Health Care.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	The report examines some contributory factors.	
3.3	Recommendations relating to the findings and that lead to a change in practice are set out.	Recommendations are set out.	
3.4	Recommendations are written in full, so they can be read alone.	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome focussed.	Recommendations are measurable and outcome focussed.	

Appendix D – Family questions

	Family questions	Section
1	Why was Mr D sent to Kent? He had been in hospital in Barrow before he absconded, and he was found in Blackpool.	6.154,6.155,7.56 to 7.70
2	Why would the doctor in Kent not talk to the local doctor to make arrangements for Mr D to return to local care?	7.77 to 7.106
3	Why was Mr D discharged from Kent, without anyone being told or being given the opportunity to comment? His parents thought he would not be released until “he sees a judge”.	7.88 to 7.106
4	Why did Mr D arrive in the middle of the night from Kent?	Not known
5	What were the arrangements for Mr D’s medication when he was discharged from Kent?	7.107 to 7.122
6	Why was Mr D told that Mr M was responsible for getting him sectioned? This was a meeting in Carlisle attended by both his parents.	6.127,7.167,7.200, 9,4 to 9.48

Appendix E – NICE guidance review

Standards	Available to J
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	Yes.
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental health care provider.	Yes.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes).	Not applicable.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	No evidence.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Monitored by the GP, bloods challenging because of beliefs about needles.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	As above.

Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	Offered.
Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	Offered.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	Offered.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Offered.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Offered.
Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should be available as needed and have a positive message about recovery.	Not offered.
Include carers in decision making if the service user agrees.	Yes, routinely.
Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	Not offered.

First episode psychosis standards.	Yes.
Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.	Yes.
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	Yes.
Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	Yes.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender and level of vulnerability, support their carers and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication in conjunction with • psychological interventions (family intervention and individual CBT).	 Yes. Yes.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication.	Yes.
Offer CBT to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.	Yes.

Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.	Yes.
Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.	No.
Behaviour that challenges	
Occasionally people with psychosis or schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines.	Not applicable.
Follow the recommendations in self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia.	Not applicable.
Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.7.1	Yes.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2	Yes.
Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.	Yes.
Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment.	Yes.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	No.
Consider offering depot/long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode? • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	No.

Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics) • take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.[101]	Yes.
Employment, education and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or are unsuccessful in finding employment.	No.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	Yes.

[101] *British National Formulary*. https://bnf.nice.org.uk/

Appendix F – Professionals involved

Organisation	Role
The Trust	• Care coordinator • Psychosis lead • Consultant psychiatrist – Hadrian Unit • Consultant psychiatrist – EIP • ALIS practitioner • Mentally Disordered Offender Manager MARE coordinator • Ward manager – Dova Ward • EIP practitioner • Investigator and SI report author/ Head of Safety • Consultant psychiatrist – Dova Ward • Ward manager – Hadrian Unit • Bed manager • Bronze on call • Chief Operating Officer
Cygnet Health Care	• Investigator and SI report author/ Consultant forensic psychiatrist • Medical secretary • Consultant psychiatrist • Mental Health Act administrator • Ward manager – Bearsted Ward • Ward doctor – Bearsted Ward • Consultant forensic psychiatrist
Cumbria County Council	Domestic Abuse Coordinator
NHS Morecambe Bay CCG	Senior Manager Strategy, Planning and MH Lead