Independent investigation into the care and treatment provided to VC

January 2025

Executive Summary

NHS England commissioned Theemis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. Theemis Consulting Ltd is a consultancy company specialising in systematic investigations and reviews. The terms of reference for this investigation were agreed with NHS England and representatives from the families involved.

1. Review the Trust internal investigation report and assess the adequacy of its findings and recommendations. If appropriate build on the findings of the internal investigation to avoid duplication.

2. Compile a full chronology of VC's contact with Mental Health, Primary Care and any other partners, including independent providers, to determine if his healthcare needs and risks were fully understood.

3. Review the interactions with services, including risk assessment and management plans, in line with Trust Guidance, National Policy and best practice.

4. Review the adequacy of risk assessments and risk management processes and what plans were put in place to mitigate those risks.

5. Determine whether there were any missed opportunities to engage, listen to and support VC and his family.

6. Describe the systemic approach to the communication of risk across the healthcare system for patients with severe mental health problems.

7. Consider how NHS services identified and managed the risk relevant to VC.

8. Consider and comment on the key "touch points" in the system, identifying any weaknesses in systems and processes, both within organisations and

across systems, and the extent to which these factors may have influenced the responses to VC.

9. Examine the events leading up to his discharge from services, the discharge planning and onwards communication with Primary Care.

10. Examine any interactions with services following the discharge from mental health services and communication.

11. Examine any interactions with family, friends and organisations in the lead up to June 2023.

12. Involve all the families affected to the extent of the families wishes, in liaison with family support organisation, advocacies and NHS England

13. Provide a written report to NHS England that includes measurable (SMART) and sustainable recommendations that have been co-produced with the affected organisations.

14. Produce a learning document, suitable for sharing with other organisations both regionally and nationally on the key learning from the investigation. Produce a version of the report suitable for publication.

15. Consider Equality Diversity and Inclusion (EDI) factors that may emerge or influence decision making.

The purpose of this investigation was to identify learning for NHS delivered care from the care and treatment provided to VC. The investigation covers the period from when VC first came into contact with mental health service in May 2020 up to 13 June 2023 when he killed three people and seriously injured three others. The investigation focuses on identifying learning at a local, regional and national level to reduce the likelihood of a reoccurrence of the tragic events perpetrated by VC in June 2023.

Methodology for this independent investigation

This independent investigation adopted a systems approach to understanding the care and treatment provided to VC. A systems approach required the investigation team to consider both the context and circumstances in which the treatment for VC's mental health condition was provided and the challenges to ensuring he received appropriate care and support.

The investigation involved three phases - evidence collection, evidence analysis and interpretation of analysis to develop findings that inform the recommendations made.

Lived experience review

The independent investigation also engaged two experts by lived experience who provided incredibly helpful insight into various aspects of the mental health system and its processes. We spent two days with lived experience experts to walk through VC's engagement with mental health services and talked through key themes identified from the evidence analysis.

The independent investigation also sought to undertake focus groups with those who are currently engaged with EIP services at the Trust and or their carers or family. We met with one individual who is currently on the EIP pathway and a family member of an individual on the EIP pathway. Separately, they gave their open and honest views of the service which has been considered as part of this work.

The incident

On 13 June 2023 VC stabbed Barnaby Webber and Grace Kumar O'Malley, both 19 years old, as they were walking back to their student accommodation at 4am. Both Barnaby and Grace, who were first year students at the University of Nottingham, died as a result of their injuries. VC then went on to stab and kill Ian Coates a 65-year-old caretaker. VC stole Mr Coates' van and drove the van into three other individuals, causing serious injury. On 28 November, VC pleaded not guilty to three

counts of murder but guilty to manslaughter on the basis of diminished responsibility. He also pleaded guilty to three counts of attempted murder. VC was made the subject of a Hospital Order, under Section 37 of the Mental Health Act 1983 for all six offences committed. Section 41 of the Mental Health Act 1983 was also imposed, which prevents VC being granted leave, transferred to another hospital or discharged without the consent of the Secretary of State for Justice.

Chronology

24 May 2020	VC's first arrest/first mental health presentation. He was sent home from the police station the same day following a mental health assessment. The plan was for VC to be followed-up by the Crisis team.
24 May 2020	VC was re-arrested for a similar offence shortly after being sent home. This resulted in his first detention in hospital under Section 2 of the Mental Health Act (MHA) 1983 the following day.
17 June 2020	VC was discharged back to the community under the Crisis team.
30 June 2020	VC's care was moved to the Early Intervention in Psychosis (EIP) team for voluntary engagement.
13 July 2020	Police incident. This resulted in VC's second detention under the MHA. VC was subsequently detained in hospital under Section 3 of the MHA.
31 July 2020	VC was discharged from hospital to the care of the Crisis team. On 13 August 2020, VC's care was then transferred back to the EIP team.
29 May 2021	VC's family recognised that his mental health was deteriorating and contacted mental health services. VC was assessed but not considered to require a hospital admission.
19 August 2021	VC's condition noted by EIP staff to be deteriorating and an increasing lack of engagement from VC was noted.
3 September 2021	VC was taken to a place of safety on a Section 135 of the MHA. He was subsequently detained on a Section 2 of the MHA and remained in seclusion in a 136 Suite while a suitable inpatient bed became available.
11 September 2021	VC's third hospital admission to hospital. He was sent to an out-of-area private hospital provider under Section 2 which was converted to a Section 3 on 24 September 2021.
1 October 2021	VC was moved to a different private hospital back within the area he was from under Section 3 of the MHA as part of step-down care.
22 October 2021	VC was discharged back into the community under the voluntary care of the EIP team.
18 January 2022	VC was detained at a place of safety following an alleged assault on fellow university student.
19 January 2022	VC was assessed for detention under the MHA but not detained as the assessing doctor considered that VC could be managed by the Crisis team and was not detainable.
28 January 2022	VC's fourth hospital admission under Section 2 of the MHA, due to lack of concordance with the Crisis team.
24 February 2022	VC was discharged from hospital back to the voluntary care of the EIP team.
28 April 2022	VC's care was transferred to a new EIP care coordinator.
23 September 2022	VC was discharged back to his GP due to non-engagement. No further records or engagement with health services is noted.
13 June 2023	VC killed three people and seriously injured a further three people.

VC's contact with mental health services

VC first came into contact with mental health services on 24 May 2020, at the age of 28, when he was arrested for criminal damage to a neighbour's flat. A Mental Health Act (MHA) assessment was undertaken, and the documented impression was that VC was experiencing a first episode of psychosis brought on by sleep deprivation and social stressors, (course work and upcoming exam). Given that VC said that he acknowledged that he was unwell and needed help, he was not detained under the MHA. He was instead referred to the Crisis Team for assessment and treatment with medication (Olanzapine 2.5 mgs at night and Zopiclone 7.5 mgs at night was prescribed).

Shortly after returning to his home, VC tried again to gain access to a neighbour's flat. The neighbour was reportedly frightened and jumped out of the first-floor window, resulting in injuries requiring hospital treatment. VC was arrested. He was not considered to have the capacity to consent to hospital admission and was therefore detained in hospital under section 2 of the Mental Health Act, following assessment at the police station. He was assessed and documented as being a risk to himself and others and was described as distracted and actively psychotic.

During his admission, on 5 June 2020, the treating consultant met with VC and his family. The consultant's documented clinical opinion was that VC was suffering from a first episode of psychosis that would require treatment. VC was described as accepting of the need to start medication. It was explained that his consultant would commence VC on Aripiprazole[1] later that day. VC remained in hospital until 17 June 2020 when he was discharged back to the care of the community – firstly with the Crisis team and then onto the Early Intervention in Psychosis (EIP) team once it was established that VC was going to remain in the area.

[1] Aripiprazole is an antipsychotic medicine that works by affecting chemicals in the brain such as dopamine and serotonin. It does not cure the condition, but it can help with the symptoms. It is used in conditions such as Schizophrenia.

VC remained in the community from 17 June 2020 until 13 July 2020. During this period, he spent the first two weeks under the care of the Crisis team where the majority of the meetings with VC took place by phone due to the COVID-19 pandemic. He spent the second two weeks under the care of the EIP team who had limited contact with VC during this time but spoke with VC's mother who raised concerns about her son's mental health. On 11 July 2020, VC's mother contacted mental health services as she felt that VC's mental health was deteriorating. It was explained to her that her message would be passed to his care team. VC's care coordinator attempted to return her call on 13 July 2020.

Also on 13 July 2020, the Police were contacted by VC's neighbours. VC had attempted to push past a neighbour into their flat. He was restrained on the floor by a number of residents until Police arrived. VC was assessed under the MHA and detained on a Section 3. It was documented that VC needed to re-start his medication - Aripiprazole immediately. He remained in hospital until 31 July 2020.

At the point of discharge back to the community, VC was considered to have a primary diagnosis of paranoid schizophrenia and was to continue with antipsychotic medication. He was initially discharged to the care of the Crisis team to support him to take his medication, and his care was then handed back to the EIP team on 13 August 2020. In November 2020 VC's medication (Aripiprazole) dose was increased from 10 mgs to 15 mgs. VC was seen regularly throughout November and December 2020 and January 2021. He underwent a medical review at the beginning of February 2021 and said that his symptoms had improved but did not attribute them to psychosis. His Aripiprazole medication was increased to 20 mgs a day. VC was seen by his care coordinator in April and May 2021. Towards the end of May 2021 VC's family raised concerns with the Crisis team that VC was sounding unwell, similar to how he behaved in the lead-up to his previous hospital admission. A phone call by the Crisis team to VC and a subsequent visit by the EIP team led services to conclude that there were no real concerns with VC's mental state. A further home visit took place in July at which no concerns were identified by the EIP team. However, by the end of August 2021 VC

was noted by the EIP team to be presenting with complex delusional beliefs and no longer taking his medication.

On 3 September 2021 a Mental Health Assessment was carried out during which VC significantly assaulted police officers who were there in support. The outcome of the assessment was that VC needed to be detained under Section 2 of the MHA. VC was nursed in seclusion due to his risk of violence and unpredictable behaviour from 3 – 9 September 2021 while awaiting a Psychiatric Intensive Care Unit[2] (PICU) bed.

On 11 September 2021, VC was admitted to a PICU at an out of area, independent provider because no PICU beds were available within the Trust. During this admission, VC was treated with the antipsychotic drug, Haloperidol.

On 24 September 2021, VC's Section 2 was converted to a Section 3 of the MHA. Whilst he was assessed to be concordant with his medication, he was described as still lacking insight and it was noted that his delusional beliefs of persecution and conspiracy remained. On 1 October 2021, VC was stepped down from PICU to an acute adult inpatient bed back in the area but with another independent provider. VC was still under a Section 3 at the time of his transfer. His diagnosis was documented to be Paranoid Schizophrenia. VC's medication was changed back to Aripiprazole and by the time of his discharge (22 October 2021) he was being prescribed 20 mgs a day. He was advised that he would need to remain on medication for the long term.

VC was discharged back to the care of the EIP team on 22 October 2021. VC attended scheduled appointments with his care coordinator in early to mid-November 2021. However, he then failed to attend any further appointments and attempts to contact him were unsuccessful in November and the first half of December 2021.

[2] Psychiatric Intensive Care Units or PICUs are specialist twenty-four hour inpatient wards that provide intensive assessment and comprehensive treatment to individuals during the most acute phase of a serious mental illness.

On 17 December 2021, VC collected his medication from the centre where his care coordinator was based and was documented as being curt with the receptionist. VC then missed his next four appointments and failed to answer the phone on 31 December 2021 and 6 January 2022. VC missed a fifth appointment on 17 January 2022. The following day, VC's care coordinator received an email from the University flagging an incident which had occurred the previous day. It was reported that VC had allegedly assaulted his flatmate and trapped him and their other flat mate in their accommodation requiring the Police to be called. The University were therefore concerned about VC remaining in the accommodation.

On 19 January 2022, VC underwent a Mental Health Act (MHA) assessment. He was not detained as he agreed to Crisis team intervention with daily visits to supervise him taking his medication. VC was seen daily by the Crisis team until 25 January 2022.

On 27 January 2022 a further MHA assessment was planned after discussion with the community consultant psychiatrist as there were ongoing concerns about medication concordance. VC was subsequently detained under Section 2 of the MHA. VC remained in hospital until 24 February 2022. At the time of the discharge VC was no longer under section of the MHA which meant, as with previous discharges, that he would be engaging with mental health services on a voluntary basis. His medication was to continue as Aripiprazole 20mgs once a day.

VC attended his planned medical review with the community consultant psychiatrist as an out-patient on 14 March 2022. No changes were made to VC's medication or management plan, and it was documented that VC would be reviewed again in three months.

On 28 April 2022 the EIP team made the decision, as part of a multi-disciplinary team (MDT), to transfer VC to a new care coordinator. VC attended the centre, where his care coordinator was based, fortnightly to collect his medication between 13 May 2022 and 15 June 2022. VC failed to attend his three-monthly medical review with the EIP consultant psychiatrist on 13 June 2022. VC attended to collect his medication on 4

July 2022. Later that month, when contacted by the EIP team to arrange medication collection, VC said that he was out of the country and would not be returning until October 2022. VC's mother was able to confirm that VC was in fact still in the UK.

VC's care coordinator continued to try to contact VC by phone and on 4 August 2022, he carried out a home visit with a colleague, but the address appeared to be incorrect. He documented that potential options would be to discharge VC to the GP or report him as a missing person.

On 17 August 2022 VC's care coordinator wrote to VC at a new address to try to arrange a meeting but received no response. VC was discussed at the MDT meeting on 18 August 2022. On 23 September 2022 it was documented that as no contact had been made with VC, a decision was made at an MDT meeting on 22 September, to discharge VC back to his GP due to non-engagement. A letter to VC's GP was written the same day, outlining non-contact and that VC had been discharged.

There was no contact between VC and mental health services or his GP between this date and the tragic incidents in June 2023.

Key findings

In this section, key findings from each main area of the report are documented. The full findings are contained within the main report.

Key findings in relation to VC's care and treatment

Finding

The approach to risk assessment in relation to VC did not appear to focus on evaluation and evidence of the effectiveness of the controls in place to manage relevant risks. The clinical judgment made on discharge from hospital will have made sense based on observations and conversations with VC at the time. However, in the more arms-length community context, the information that inpatient clinicians relied upon to make their decision was contradicted by the observations of staff seeking to engage VC and his family. The context of care would seem a critical factor for risk assessments completed across inpatient and community teams to understand the implications for the reliability of approaches to risk mitigation and decisions around treatment and discharge.

The way in which risk was being documented and formulated was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings. For example, VC's risk in hospital would have been different from when in the community where hazards such as non-concordance and disengagement from services may have led to new or increased risks. The risk assessment's formulation section reads as a list of previous violent behaviour rather than a true formulation and therefore does not demonstrate active risk control or understanding of the impact in change of effectiveness of protective factors. In the community, the section of the risk assessment form does not detail the actions taken or needed to attempt to minimise or mitigate known risks. Hence, reviews may not focus on how effective the intended controls were at that time or in the context of the setting.

Finding

The prioritisation of a positive risk management approach may have impacted the ability to achieve medication concordance, engagement with services and an increased level of insight. Instead, a dynamic approach to risk management would provide the opportunity to consider clear points at which to move from positive risk management to taking a more restrictive approach. This would support the management of hazards as they presented and ultimately support VC with the long-term management of his mental health condition.

Finding

The voice of VC's family was not effectively considered to support the dynamic evaluation of risk.

Finding

VC's concordance with medication was in question shortly after each discharge from hospital. Sometimes his partial concordance was explained away by his misunderstanding of the number of tablets to take at a time and by forgetting to collect his medication. Even when under close observation by the Crisis team in January 2022, they experienced difficulty in determining his medication concordance.

On each hospital admission there was an opportunity to consider putting in place arrangements for depot medication. This was not agreed to by VC and the decision was made not to administer depot medication. By the time VC was on his fourth admission there was a pattern of concordance in hospital and non-concordance in the community both with his medication and with his willingness to engage with his clinical team.

During his admissions under Section 3 of the MHA, there was the option to discharge VC under a community treatment order (CTO). A CTO can incorporate conditions, including a condition to comply with depot medication, with the option of recall to hospital if non-compliant. This provides a level of compulsion in the community that is otherwise not possible. The EIP team were seeking this intervention for VC to support his engagement when he was disengaging from services. A CTO could have also provided VC with the opportunity to explore how he felt when he was appropriately medicated.

The inpatient teams involved in VC's care were trying to treat VC in the least restrictive way and took on board VC's reasons for not wanting to take depot medication which included him not liking needles. His wishes were balanced against the fact that he was judged to have capacity and taking his medication on the ward which assured the team he was willing to take his medication in the community and work with the community team. On the fourth admission he was not displaying active symptoms of psychosis and the clinical team considered that they could not justify a move to a Section 3 of the MHA at that time. The early use of a CTO provides the opportunity to recall an individual to hospital in the event of a deterioration in the community under the CTO provisions within the MHA.

Key findings in relation to VC's diagnosis and medication

Finding

A theme running through VC's clinical records is that he did not consider himself to have a mental health condition. His insight into his condition did not appear to increase and therefore his understanding of the importance of medication in his case never appeared to be understood by VC. Whilst he may have clinically improved during his inpatient stays, he did not demonstrate retrospective insight. This is an important factor to consider when looking for an understanding of an individual's mental health.

Key findings in relation to VC's capacity

Finding

VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement, particularly in the community. There does not appear to be a systemised approach to assessing patient capacity based on presentations across care settings and relied upon in the context of voluntary treatment within the community. Therefore, the question of capacity does not appear to inform all assessments of risk across the different care settings.

Key findings in relation to decision making

Finding

The investigation team consider that whilst decisions made were thought to be appropriate by those involved at the point at which they were made, what appears to be missing is shared decision making across all teams involved in VC's care. The community team fed into discussions about VC's care and their concerns about his non-concordance in the community. However, ultimately the decision appears to lie with the inpatient consultant as the Responsible Clinician. There are complexities with the Responsible Clinician having to make a clinical decision when the individual's presentation contradicts what is being reported from a longitudinal perspective.

The way that the system is configured, the emphasis is placed on the inpatient Responsible Clinician to make discharge decisions. If the system required inpatient and community consultants to have shared responsibility and joint decision making, then the autonomy of a single clinician (Responsible Clinician) might avoid the dominance of a perspective based on observations from one clinical setting.

The guidance states that, if the individual has a care coordinator in the community, then they should be involved in any discharge planning. Guidance also suggests that families or carers should also be involved in discharge planning. However, interviews from this investigation suggest that ultimately the Responsible Clinician makes the discharge decision. There is therefore a bigger question about why the culture appears to promote an individual in a specific role making the decisions even if this is at odds with the guidance and views of others involved in an individual's care.

Key findings in relation to the use of assertive outreach

Finding

NHS England's recent review and guidance indicates that assertive outreach should be a discrete resource but recognises while some ICBs may already commission 'assertive outreach' teams or similar, others may not currently commission a specific team or service focused on intensive and assertive approaches. This aligns with the information and evidence provided to the independent investigation that suggested the majority of dedicated assertive outreach teams as a standalone function, were disbanded over 10 years ago. Alternative models for supporting service users who do not choose to or are unable to engage with mental health services have developed but there is variation in the approach, dedicated protected resources and in outcomes for patients. VC's clinical records and interviews with community Trust staff do, to an extent, demonstrate an element of an assertive approach. However, this was constrained by the service model and workload within the team.

Key findings in relation to the use of out of area placements

Finding

Nationally, it is recognised that it is best to deliver care locally wherever possible and the aspiration is to not use spot-purchased out of area placements. In VC's case, the Trust had to send VC to a PICU bed and then an acute bed out of area due to a lack of local capacity. Whilst the records suggest that he received regular assessments and, where possible, Care Coordinator 1 attended ward rounds virtually, it is recognised nationally, that something is lost by not keeping care delivery local. In VC's case, these admissions came at an important point in the treatment of his mental illness, in that a pattern of his engagement as an inpatient versus non engagement in the community was forming. This may have been the opportunity to fully see the pattern and to take seriously the concerns of Care Coordinator 1 and consider using the time VC spent on a Section 3 to explore a Community Treatment Order.

Key findings in relation to the discharge back to primary care

Finding

The absence of robust Trust discharge processes and a record template, which enabled engagement with primary care and the family resulted in limited consideration and quality in the effectiveness of the transfer of care and management of risks. The Trust told the independent investigation that a more robust approach to discharge from services has been included in the updated Transfer and Discharge policy (May 2024).

Finding

The investigation identified that non engagement with the EIP team has become an accepted reason for discharge, recognising the context that the EIP team had made several requests to increase their ability to ensure engagement through a CTO and without this had limited ability to create a situation that enabled them to assess and deliver treatment in the community setting.

Finding

Discharge in the absence of a face-to-face meeting with a patient creates the potential for greater risk to the person using mental health services and to others. Normalisation of such discharges appears to be influenced through demand on services tempered with limitations in non-restrictive practices that can still achieve engagement of patients reluctant to meet voluntarily with community-based clinicians.

Finding

There appears to have been a drift in practices in the discharge of mental health patients back to the GP which has resulted in a lack of meaningful communication and planning to manage recognised risks.

Finding

Communication with primary care appears to be of low priority in the context of mental health patients treated within the Trust. The design, integration and accessibility to technical systems used across acute and community settings impedes access and visibility of patient risks to primary care clinicians.

Finding

EIP staff were working with caseloads beyond the recommended level and the complexity and acuity of service users was not reflected in allocation of workload. There appears a lack of Trust oversight to identify signs in the ability for frontline staff to effectively deliver the model of care intended by the Trust.

Finding

The constraints around resources to manage disengagement and limited Trust oversight did not sufficiently alert the Trust to the normalisation of a compromised delivery of care.

Key findings in relation to oversight, assurance, risk assessment and management

Trust oversight

Finding

Ahead of the COVID-19 pandemic there was evidence to suggest that Trust governance structures and processes needed strengthening to ensure 'ward to board' viability of key information.

Finding

The investigation considers the impact of COVID-19 may have compounded existing issues around organisational structure and change. A lack of organisational stability, effective structures and processes impeded the visibility and oversight of organisational risks.

Finding

The investigation established existing processes and organisational approaches to managing incident data and reports of events specific to harm to others did not support effective oversight and provide opportunities to learn. Furthermore, effective follow up actions to understand how the organisation intended to improve their approach to the management of this risk were absent. This highlights the absence of a robust approach to risk management with an absence of assurance to the Board on the evaluation and effectiveness of intended controls. A robust risk management approach would also include transparency of remaining risks to be held at Board level for which controls were limited.

Finding

The frontline risks created by workforce issues and the increased use of subcontracted providers did not appear to be visible at Board level. Instead, the risks appeared to be primarily managed by community NHS staff who told the investigation they made efforts to regularly contact independent providers to share information and seek to identify imminent meeting dates.

Finding

The lack of a systemic and systematic approach to risk management prevents the Trust from fully understanding and mitigating known risks and provide transparency to risks absorbed by frontline staff.

Integrated Care Board (ICB) oversight

Finding

There were limitations with the assurance and oversight arrangements at the ICB in 2023. The arrangements were not formalised or robust enough to provide the opportunity to fully identify signals of issues with safety and risk. Nor were the governance arrangements mature enough to triangulate intelligence with partner organisations.

Finding

Evidence suggests that whilst the ICB were aware of concerns regarding risk and safety at the Trust, they were not fully assured around the ability of the Trust to make or sustain the required improvements.

Whilst there is evidence of the ICB monitoring concerns, the arrangements in place to assure themselves of appropriate action being taken were still maturing and did not allow for the ICB to assure themselves of improvements in a timely manner.

Finding

Evidence suggests that at all levels of the regional healthcare system there was a level of knowledge about the challenges faced by the Trust. Despite this knowledge, the risk remained for Trust frontline staff to manage.

Finding

The processes in place for oversight and assurance did not provide a systematic approach to risk management.

Wider system oversight

Finding

There were limited effective processes in place for ensuring the sharing of knowledge between the Trust and the Police to inform estimation of risk and insight on effectiveness of care and treatment.

Finding

Organisational structure, processes and technical systems create limitations in ensuring the reliability and quality of safety critical information is available to all relevant stakeholders. Without appropriate mechanisms in place, there are limitations with the timely sharing of important information to those involved, including the family.

Recommendations

National recommendations

Area for improvement 1 – Care delivery

We found that the offer of care and treatment available for VC was not always sufficient to meet his needs. This included the service having difficulty in providing VC with support when he did not wish or was unable to maintain contact with services. From conversations with others as part of this review, we believe that the experience of VC was not unique in how some people with severe and enduring mental illness are supported by mental health services.

We recognise that NHS England is aware of the need to improve the quality and effectiveness in a number of areas and has developed several programs of work to drive this forward to improve the outcomes and experience for people who use mental health services. Our findings suggest that there needs to be significant continued focus at all levels to meet the mental health needs of people and the communities served.

Recommendations

NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

National leaders should, in the next six months, include, as part of this debate, the following key areas:

- The demands on mental health services have increased over recent years. Services are often delivered across complex multi-agency systems. People who use mental health services frequently have multiple needs that require significant support to enable them to live well. National leaders must be

confident that the financial resources currently available are sufficient to meet the needs of those experiencing severe and enduring mental illness.

- What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of relevant parts of the Mental Health Act.
- The debate should ensure that the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds in the context of increasing demand and acuity. This must be supported by sufficiently trained and developed workforce, including people with lived experience.
- The dissonance between what people think should be happening, for example care described in national policies and guidance compared to what is actually being delivered in some services.
- The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions.
- That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice and co-produced with people with lived experience. Commissioners should assure themselves that services they are commissioning are being delivered as intended.
- Whether the recurring, common themes that are identified in similar reviews are an accepted risk in the system or whether there are fundamental changes that can be made to mitigate these risks further.

Area for improvement 2 - Risk

We found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience suggests that this issue is not isolated to this case.

Recommendations

NHS England should, in the next six months consider:

- How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures.
- What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.
- How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need.
- Given that The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes.

Local recommendations for the Trust

These recommendations are made with the anticipation that there will be collaboration across the healthcare system to achieve the required change. Whilst these recommendations are directed at the Trust who provided care and treatment for VC, all Trusts need to assure themselves in the following areas.

Area for improvement 3 – Recommendation implementation

We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.

Recommendation

- The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process.

Area for improvement 4 – Serious incident policy

We found that the Trust's serious incident policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.

Recommendation

The Trust needs to ensure that its Patient Safety Incident Response is in line with NHS England's new patient safety framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.

Area for improvement 5 – Family engagement

We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.

Recommendation

- The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care[3] and the Patient and carer race equality framework[4]), to support effective family engagement. The new processes should inform decisions on care, treatment and the management of both safety and risks.

[3] The Triangle of Care (carers.org)
[4] NHS England » Patient and carer race equality framework

Area for improvement 6 – Clinical information sharing

We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.

Recommendation

- The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.

Area for improvement 7 – Across organisational working

We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.

Recommendation

- The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.

Area for improvement 8 – Governance arrangements

In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.

Recommendation

- The Trust and the Integrated Care Board should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.

Area for improvement 9 – Policy development and review

We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day to day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.

Recommendation

- The Trust should ensure that all Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. Where appropriate, policies should be coproduced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.

Area for improvement 10 – Peer support

In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.

Recommendation

- As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.

Area for improvement 11 – Care planning

We found limited evidence that care planning arrangements were co-produced with VC and his family. Building on area for improvement 5, once the Trust has developed its family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family.

Recommendation

- The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.

Area for improvement 12 – Joint clinical decision making

We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.

Recommendation

- The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.

Contents

Glossary

Sources for the following definitions are: NICE guidelines for Anti- Psychotic drugs, NHS England for definitions of Psychosis and treatment and for medical terms, Nottinghamshire Healthcare Foundation Trust for definitions of services, The Crown Prosecution Service. RCOT (Royal College of Occupational Therapists)

Term used.	Definition
AMHP (Approved Mental Health Professional)	The AMHP is independently responsible for a decision to detain a person and arrange conveyance to hospital.
Acute Psychological Interventions Practitioner	This psychological role offers support to people with mental health problems in helping them identify areas where the person wishes to change how they feel, think or behave.
Auditory hallucinations	Sensory perceptions of hearing voices in the absence of external stimulus – can refer to a range of sounds
Bridewell Custody Suite	Bridewell is a police station which contains a custody suite. It is a place of safety where an individual can be assessed under the Mental Health Act
Capacity	Assessing capacity under the Mental Capacity Act (2005) involves an assessment of the person's ability to use and understand information to make a decision and to communicate any decision making.
Care Coordinator	A care coordinator's role is to effectively bring together multidisciplinary teams to support people's complex health and care needs.
CPA (Care Programme Approach)	CPA is a package of care which is used by secondary mental health services to assess, plan, review and co-ordinate the range of treatment, care and support

	needed for people in contact with the service who have complex care needs.
Clinical Psychologist	A Clinical Psychologist works in assessing clients' behaviour and needs via observation, interviews and psychometric tests. They work in developing, administering and monitoring treatment therapies and strategies.
Cognitive deficit	Problems with memory, language or judgement. These are usually symptoms of an underlying condition.
CTO (Community Treatment Order)	This allows a person who has been detained in hospital under section 3 or section 37 of the mental health act to be discharged to be treated in the community. If the person becomes unwell or does not follow the conditions of the CTO, they can be recalled to hospital.
Compliance	Compliance is a measure of the extent to which patients follow a prescribed treatment plan, including taking medicines.
Concordance	An agreement between a patient and health care professional based on how, when and why medication should be taken.
Conditional caution	Criminal Justice Act (2003) requires an offender to comply with conditions as an alternative to prosecution. It avoids the need for a court hearing and is a disposal at the police action stage. It is a suspension of prosecution, but if conditions are not complied with, a prosecution may go ahead.
CRHT (Crisis and Home Treatment Teams), Crisis and CCT (City Crisis Team)	Crisis teams provide both an intensive and rapid response service to users in crisis and

	living at home. This is particularly important where there are concerns that a deterioration in mental health could result in a hospital admission to avoid the risk of harm to self or others.
A depot	An injection of a medication which releases slowly over time to permit less frequent administration of a medication. An antipsychotic depot injection is often used to increase medication adherence and consistency.
EIP	Early Intervention in Psychosis. These are multidisciplinary teams working in the community to support and treat people experiencing or at high risk of developing a first episode of psychosis. Interventions include medication, psychological therapies and psychological education for a period of up to 3 years, with the aim of offering quick access and timely treatment in order to maximise opportunities for improved longer term outcomes. Care coordinators work with these teams.
Forensic services (Community Forensic Services)	Forensic services provide specialist interventions, managing patients with mental disorders who have been or have the potential to be violent.
Functional illness	Where no organic (example dementia) cause can be found.
IM Injections (Intermuscular injections)	Intramuscular injections are injections which go into the deep muscle.
Integrated Care Board (ICB)	ICBs are NHS organisations responsible for planning health services for their local population. They manage the NHS budget and work with local providers of NHS services, such as hospitals and GP practices, to agree a joint five-year plan.

L and D (Liaison and Diversion Services). Also MHLD (Mental Health Liaison and Diversion Services)	This service identifies people with mental healthcare difficulties when they encounter the criminal justice system and divert them into a more appropriate setting if required.
Medications	Aripiprazole: an atypical antipsychotic used to treat symptoms of psychosis in people with a diagnosis of schizophrenia or suffering from psychosis. Diazepam: prescribed for anxiety. Haloperidol: an antipsychotic medication. Lorazepam: prescribed for anxiety and sleep problems. Olanzapine: an antipsychotic medication. Zopiclone: prescribed for insomnia/sleep problems.
MHA (Mental Health Act)	The MHA of 1983 is supported by the 2015 code of practice which sets out guidelines for its use. Section 135 is a warrant which gives the police the powers to enter a home, if needs be by force, if someone is deemed to be of harm to themselves or others. Section 136 gives the police the power to remove a person from a public place when they appear to be suffering from a mental disorder to a place of safety where a Mental Health Assessment (MHA) is undertaken. See Bridewell Custody Suite. In addition to a police station, a S136 Place of Safety – could also be A&E, or Mental Health s136 suite. Section 2 MHA allows the detention of an individual for assessment in hospital for up to 28 days. Section 3 MHA allows the detention of an individual for treatment in hospital for up to

	6 months. This is also known as a Treatment Order. Section 17 MHA allows for an individual detained under MHA to be granted leave of absence from hospital subject to specified conditions. Section 37 MHA is a Hospital Order which the criminal courts can use if they think an individual should be in hospital instead of prison. An individual must have a mental disorder and need treatment in hospital and have been convicted of a crime that is punishable with imprisonment. Section 41 MHA is a Restriction Order. It means that an individual cannot be discharged from hospital unless the Secretary of State for Justice or a Tribunal says they can leave. An individual's discharge may then be subject to certain conditions.
MHAS (Mental Health Advisory Service) Also University of Nottingham MHAS	The MHAS is a Nottingham University service made up of a team of specialists who provide specific support to students experiencing significant mental health difficulties. Student access to MHAS is by referral from staff only.
MDT meeting (Multi-Disciplinary Team meeting	MDT meetings are a forum for differing professional groups - health and care staff to discuss complex cases and consider possible treatment plans/pathways and access support and advice from a multi-disciplinary team.
OT (Occupational Therapist)	An OT helps people overcome challenges completing everyday tasks or activities.
PRN (Latin: pro re nata)	PRN medication is taken as needed.
PICU bed	This is a bed in the Psychiatric Intensive Care Unit
Psychosis	This is when people lose some contact with reality. This might involve hallucinations

	(seeing or hearing things that other people cannot see or hear) and delusions (believing that things are not true). It may also involve confused or disordered thinking or speaking. Experiencing the symptoms of psychosis is often referred to as having a psychotic episode. Schizophrenia is a mental health condition that causes a range of psychological symptoms, including hallucinations and delusions.
Street Triage	This team is a partnership between Nottingham Healthcare, Nottingham Police and local Integrated Care Boards (ICBs). It joins up mental health practitioners with police officers to provide a specialist response to people with mental health issues. They signpost patients to the appropriate service.

1 Learning report

1.1 The purpose of this investigation is to identify learning from the care and treatment provided to VC. The investigation covers the period from when VC first came into contact with mental health service on 24 May 2020 up to 13 June 2023 when he killed three people and seriously injured three others. Identifying learning at a local, regional and national level is designed to reduce the likelihood of a reoccurrence of the tragic events perpetrated by VC in June 2023.

2 Introduction

2.1 Summary of events

2.1.1 On 13 June 2023 VC stabbed Barnaby Webber and Grace Kumar O'Malley, both 19 years old, as they were walking back to their student accommodation at 4am. Both Barnaby and Grace, who were first year students at the University of Nottingham, died as a result of their injuries. VC then went on to stab and kill Ian Coates a 65 year old caretaker. VC stole Mr Coates' van and drove the van into three other individuals, causing serious injury. On 28 November, VC pleaded not guilty to three counts of murder but guilty to manslaughter, on the basis of diminished responsibility. He also pleaded guilty to three counts of attempted murder.

2.1.2 VC was made the subject of a Hospital Order, under section 37 of the Mental Health Act 1983 for all six offences committed. This order required VC to be re-admitted and detained at Ashworth High Security Hospital. A restriction order under section 41 of the Mental Health Act 1983 was also imposed, which prevents VC being granted leave, transferred to another hospital or discharged without the consent of the Secretary of State for Justice.

2.2 Commissioning of Independent Investigation

1.2.1 NHS England commissioned Theemis Consulting Ltd to carry out an independent investigation into the care and treatment provided to VC by NHS services prior to the tragic events of 13 June 2023. The full scope of the investigation is outlined in the terms of reference below. The purpose of the independent investigation is to identify learning for NHS delivered care.

2.3 Terms of Reference

1.3.1 The terms of reference for this investigation were agreed with NHS England and representatives from the families involved.

16. Review the Trust internal investigation report and assess the adequacy of its findings and recommendations. If appropriate build on the findings of the internal investigation to avoid duplication.

17. Compile a full chronology of VC's contact with Mental Health, Primary Care and any other partners, including independent providers, to determine if his healthcare needs and risks were fully understood.

18. Review the interactions with services, including risk assessment and management plans, in line with Trust Guidance, National Policy and best practice.

19. Review the adequacy of risk assessments and risk management processes and what plans were put in place to mitigate those risks.

20. Determine whether there were any missed opportunities to engage, listen to and support VC and his family.

21. Describe the systemic approach to the communication of risk across the healthcare system for patients with severe mental health problems.

22. Consider how NHS services identified and managed the risk relevant to VC.

23. Consider and comment on the key “touch points” in the system, identifying any weaknesses in systems and processes, both within organisations and across systems, and the extent to which these factors may have influenced the responses to VC.

24. Examine the events leading up to his discharge from services, the discharge planning and onwards communication with Primary Care.

25. Examine any interactions with services following the discharge from mental health services and communication.

26. Examine any interactions with family, friends and organisations in the lead up to June 2023.

27. Involve all the families affected to the extent of the families wishes, in liaison with family support organisation, advocacies and NHS England

28. Provide a written report to NHS England that includes measurable (SMART) and sustainable recommendations that have been co-produced with the affected organisations.

29. Produce a learning document, suitable for sharing with other organisations both regionally and nationally on the key learning from the investigation. Produce a version of the report suitable for publication.

30. Consider Equality Diversity and Inclusion (EDI) factors that may emerge or influence decision making.

3 Methodology for this independent intervention

3.1 This independent investigation has adopted a systems approach to understanding the care and treatment provided to VC. A systems approach required the investigation team to consider both the context and circumstances in which the treatment for VC's mental health condition was provided and the challenges to ensure he received appropriate care and support.

3.2 To understand what happened in this case the investigation team considered the complexity in the mental healthcare system, which includes a large number of stakeholders and requires many interactions across multiple agencies that may be situated in different geographical locations. One of the implications of this complexity is that there is significant opportunity for variability in the interactions between services. Typical variability may include how and when information is shared within, between and across services and how the information is perceived and applied to decisions made that influence care, treatment and the management of known risks.

3.3 Investigations of adverse events in complex systems require a focus on the clinical tasks undertaken together with key interactions between the people, technology, environments and organisations involved across the breadth of the system or systems.

3.4 The methodology developed for this investigation aims to reflect this complexity and provide:

- Independent assessment of the quality of the NHS and its partners' care and treatment provided against best practice, national guidance and organisational policies.
- Analysis of the evidence obtained on VC's care and treatment in the context of the existing national mental healthcare service structure, the legislation and the interaction with non-healthcare agencies (for example the University and the Police).

2.5 The approach described is recognised within the field of safety science and is based upon system theories now required by NHS England to inform healthcare safety investigations (NHS England, 2024 NHS England » Patient safety learning response toolkit). This approach is supported by evidence from many safety critical industries, which adopt the same approach, acknowledging that rarely do people who work in such systems go to work to cause harm. The tragic outcomes we investigate are a reflection of how the system has influenced those touched by the system or working within it. Therefore, it is essential to seek to understand why things made sense at the time to those involved and what controls were in place to support safety across the whole system. This provides greater opportunity for learning that may be applicable on a local, regional, or national basis and an opportunity to build a restorative and just culture for all those involved.

Phases

The investigation involved three phases - evidence collection, evidence analysis and interpretation of analysis to develop findings that inform the recommendations made.

3.4.1 Evidence collection

3.4.1.1 Interviews

The evidence collection followed investigation best practise and adopted a trauma informed approach to the interview of all those involved. The investigation commenced with early engagement with families representing all who have suffered as a result of these tragic events.

A stakeholder mapping exercise was completed to identify the roles and individuals that represented different touchpoints in the system relevant to VC's experience. Early interviews also included the family of VC and VC himself.
A detailed list of healthcare and educational roles involved can be found in Appendix I, which includes representation from:

- The Trust

- two independent providers of acute mental healthcare services,
- primary care staff
- Integrated Care Board (ICB)
- The University attended by VC

The investigation also interviewed the author of the Trust's internal investigation to explore the findings, evaluate the quality and understand the limitations as described by the author.

All interviews were recorded with written consent obtained from the staff, transcribed and then coded based on a thematic framework, see Appendix II. The coding framework was based upon a system based framework, the systems engineering initiative for patient safety (SEIPS) (Holden et al, 2013).

The University of Nottingham declined to be interviewed and provided their evidence and answers to the investigation's questions in a written form.

The investigation tried on a number of occasions to engage the Nottinghamshire Police. Nottinghamshire Police were unable to engage with the review as they remain under investigation by the Independent Office for Police Conduct (IOPC) in relation to the matters directly associated with the terms of reference of this review.

We also spoke with experts who have a detailed knowledge of the background and history of mental healthcare services in England. This provided further context to understanding the wider contributory factors which may have impacted VC's care. The investigation has used this understanding of the wider context to pose questions to the healthcare system for mental healthcare in England.

We have also considered whether some of the wider contributory factors identified as having an influence on the care and treatment provided to VC are unique to this case and/or are only occurring in Nottinghamshire Healthcare NHS Trust.

3.4.1.1.1 Document review

This included the review of publicly available papers, national policies, legislation, mental health review reports, national and professional guidance/guidelines and academic papers. This has enabled the investigation analysis to consider the evidence in the context of national recommendations, requirements and the current knowledge base relevant to mental health services and the delivery of care to people with mental health problems.

The investigation reviewed local policies and procedures in place at the time of the event produced by the Trust. We also reviewed organisational governance structures and processes, serious incident investigations and learning reports, Board papers (private and public) and internal reviews of services. Specific attention was given to policies related to cross agency working, risk assessment, communication and management, care and treatment for the different care settings and discharge planning. The time span for the document review was from 2020-2023, which reflected the period when VC was in receipt of care from the Trust. We also reviewed documentation relating to current governance arrangements at the Trust.

A review of clinical notes was completed by an independent Consultant Psychiatrist and Mental Health Nurse, both experts in their field. This provided a chronology of the evidence of the documentation of care, decision making and assessment of risks. The notes were retrieved from each care setting that VC was known to, which included:

- The Trust – inpatient and community care
- Two independent providers
- Primary care.

Evidence analysis

The analysis of complex systems requires consideration of the interactions across the system that has been designed or evolved to deliver a service. Focusing on single aspects of care and treatment or individuals alone in such complex systems may not provide learning on why and how the system may or may not control inherent risks.

The first stage of analysis aimed to identify gaps between the way the system is believed to deliver care, and the way it actually delivers care. This requires consideration of how care is delivered in the context of the clinical environment, organisational resources and the equipment or tools relied upon. This stage of analysis informed the review of care and treatment, comparing work as described within the guidance, policies and procedures reviewed with how we were told care was delivered during the interviews with staff. We also used the evidence provided by VC's family to understand the reality of the care VC received.

The second stage of analysis looked across the span of the system in the context of how risks were identified and interpreted in each clinical environment. This included how risks were communicated across care settings and how they were managed and mitigated in these relevant care settings. In particular the events and decision making, and actions related to VC's discharges were a focus for this investigation. Consideration was given to the interactions and systemic factors influencing the care and treatment received by VC was analysed from the top of the system (national policies, legislation) to the front end of clinical care settings.

Evidence interpretation

The analysis was considered through the use of an accident analysis method Accimap. Accimap has been developed to interrogate factors contributing to adverse events in complex systems (Svendug and Rasmussen, 2000, Waterson, 2021 Promoting systemic incident analysis in healthcare—key challenges and ways forwards | International Journal for Quality in Health Care | Oxford Academic (oup.com)). This approach enabled the investigation to understand why certain

outcomes occurred in the different clinical contexts, consider the factors contributing to the outcome and the controls that existed at the time intended to manage these factors and reduce or mitigate risks (Appendix III).

Lived experience review

The independent investigation also engaged two experts by lived experience who provided incredibly helpful insight into various aspects of the mental health system and its processes. We spent two days walking through VC's engagement with mental health services and talking through key themes identified through the analysis. An outline of their role and a brief summary of the two experts by lived experience is included in Appendix VI.

The independent investigation also sought to undertake focus groups with those who are currently engaged with EIP services at the Trust and or their carers or family. We met with one individual who is currently on the EIP pathway and a family member of an individual on the EIP pathway. Separately, they gave their open and honest views of the service which has been considered as part of this work.

4 Introduction

This section sets out definition, national policies and guidance relevant to this case. This section also considers some of the aspects of treatment options and research in a variety of related fields.

4.1 Definition, prevalence and guidelines for psychotic disorders, including schizophrenia

4.1.1 Definition

Psychotic disorders affect how a person thinks or perceives information that can be severe enough to distort their perception of reality. The term psychotic or psychotic

disorder is a general term which can be used to refer to several conditions including schizophrenia, schizoaffective disorder and delusional disorder. Symptoms of a psychotic disorder may include (NICE CG178, 2014, Royal College of Psychiatrist):

- Muddled, random or disconnected thoughts,
- Beliefs that your thoughts are being interfered with by an external person or thing,
- Beliefs that you are being controlled by something outside of your control,
- Hallucinations – hearing, feeling, seeing or smelling things that aren't present,
- Delusions – firm beliefs or ideas that may seem strange to others,
- Paranoid delusions – a conviction and belief that someone is intending to harm you or you are being persecuted in some way.

Schizophrenia is a long-term mental health condition that causes a range of different psychological symptoms. Schizophrenia is often described as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality. Symptoms of schizophrenia can include:

- hallucinations – hearing or seeing things that do not exist outside of the mind
- delusions – unusual beliefs not based on reality
- muddled thoughts and speech based on hallucinations or delusions
- losing interest in everyday activities
- not wanting to look after yourself and your needs, such as not caring about your personal hygiene
- wanting to avoid people, including friends
- feeling disconnected from your feelings or emotions

NICE recognise within their guidelines that these conditions are associated with stigma and limited understanding amongst the public (NICE CG178).

4.1.2 Prevalence

The prevalence of psychotic disorders in the population of the UK over the last year highlights a significantly higher percentage of black men (3.2%) have experience of a psychotic disorder (NHS Digital, 2024a).

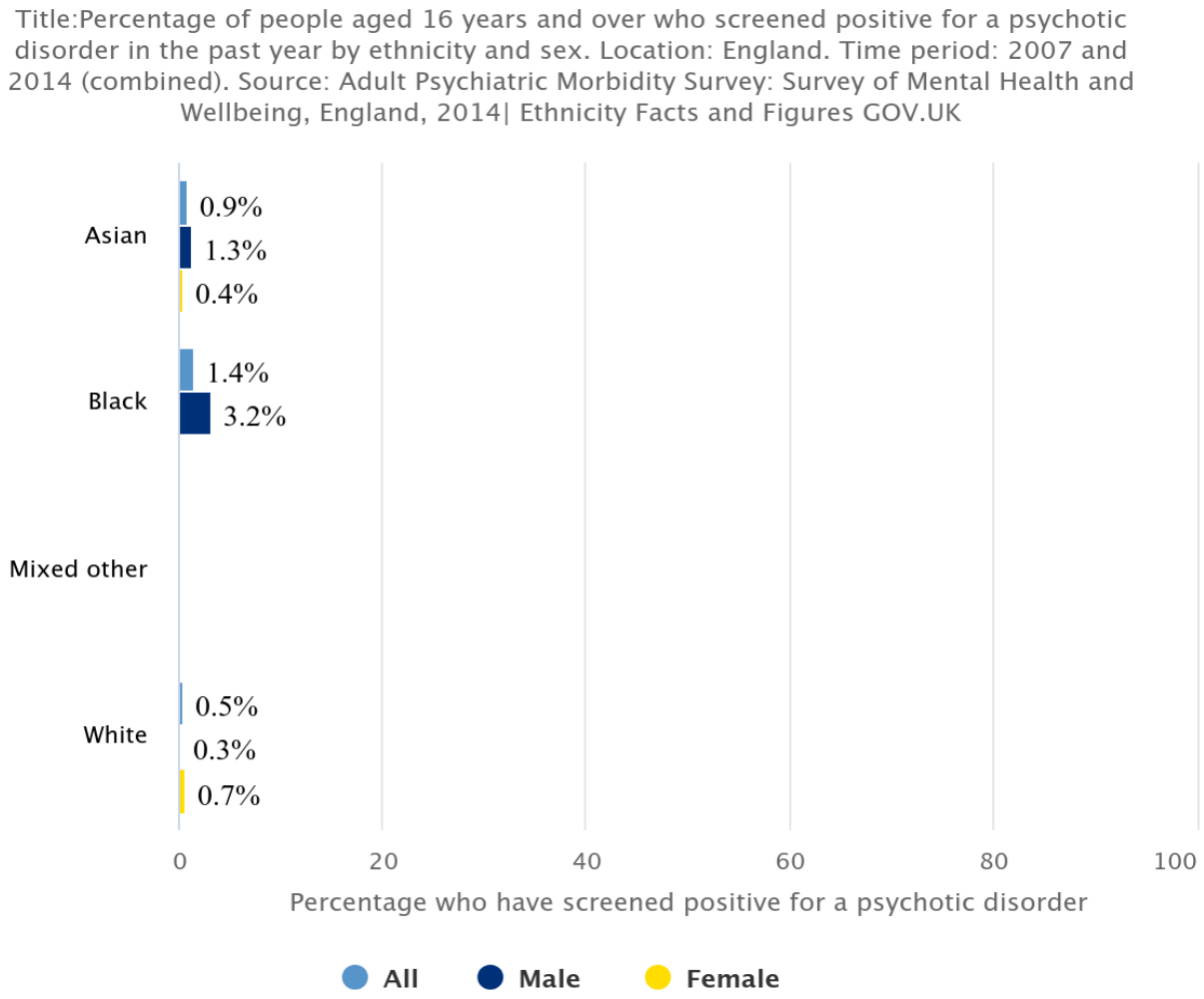


Figure 1 Prevalence of psychotic disorders in the population of the UK (NHS Digital, 2024a)

Several factors can account for the higher rates of mental illness seen within racially and culturally marginalized groups compared to privileged groups. In all, people who culturally and/or racially differ from the dominant (white) group often face many forms of systemic disadvantage, including within healthcare, which, in turn, fosters mistrust in mental health sectors that are often borne from the customs of the dominant group (Alang, 2019; Hui et al., 2021). For example, migrants and refugees often arrive in

their new country with a history of colonialism; displacement from family; and/or exposure to conflict, war, or terrorism (George, 2010; Sullivan & Simonson, 2016). These experiences increase the risk of mental illness for this population (Sangalang & Vang, 2017).

4.2 Homicides by patients with a severe mental health diagnosis

The killings of Barnaby, Grace and Ian by VC come under the category of homicides perpetrated by individuals who are experiencing severe mental health problems. The criminal justice system is able to detain those offenders in a (usually secure) psychiatric hospital for treatment of their mental disorder.

In 2002 qualitative analysis of recommendations in 79 inquiries after homicide committed by persons with mental illness was undertaken (PDF) Qualitative Analysis of Recommendations in 79 Inquiries after Homicide Committed by Persons with Mental Illness (researchgate.net). The analysis found that the reports contained numerous recommendations regarding:

- The care programme approach (CPA), assessment, care planning, risk assessment and management, and history taking.
- The need for improvements in communication between different professional groups and between agencies. The essential point is that there should be collaboration and joint working. There are recommendations about improvements to police procedures and liaison between health care agencies and the police.
- Issues relating to mental health care and treatment guidelines, evidence-based practice, monitoring of the use of guidelines or protocols, and audit.
- Issues relating to staff being trained in national and/or local guidelines and policies, which includes CPA procedures, and assessing and managing risk. Other recommendations related to staffing levels.
- There were also recommendations relating to the management of particular patient groups, recommendations were made relating to, in the event of non-compliance, patients must either be re-assessed or readmitted to hospital.

Whilst this report is now 22 years old, it is clear that the findings are still very relevant today and the points drawn out above are all relevant to VC's care and treatment. In 2015 NHS England ceased to collect and present data that reflected national trends in rates for those with a severe mental illness who committed a homicide.

The National Confidential Inquiry into Suicide and Safety in Mental Health (The Inquiry) has been running annually since 1994 to produce the numbers of patient homicides and conduct research and analysis. However, research and analysis into mental health related homicides stopped in 2018 and has since just presented the data on numbers of such cases.

In 2023 a national confidential inquiry into suicide and safety in mental health was commissioned by the Healthcare Quality Improvement Partnership (HQIP) (The National Confidential Inquiry into Suicide and Safety in Mental Health, 2023). The subsequent report suggests between 2010-2020 there were 5,876 homicide convictions. During the period 2010-2019 610 of those convicted were people under the care of mental health services. They suggest between 2010 and 2020 11% of people convicted of homicide were patients under mental health care. However, it is not possible to conclude from the report, in how many cases mental health conditions played a direct role in the homicides. There are limitations with this data as it focuses on those who have been convicted of homicide and not on:

- Patients who have not been convicted (e.g. those who kill themselves after killing others,
- Cases where a patient has killed more than one person because the methodology takes account of only one conviction,
- People who receive their mental health care from primary health care services and are not known to secondary care services,
- People who are either unable, or unwilling, to access proper care and treatment from secondary mental health services.

4.3 Legal and regulatory landscape

The law provides the ability to protect those presenting or diagnosed with mental health disorders for the purpose of their own health and safety and that of others. The law can be used to enforce different levels of restrictions and requirements to

support a person with mental health disorders to receive assessment and treatment, whilst also monitoring wellbeing and safety during periods of recovery or ongoing treatment. This section will outline the key areas of law that support these different levels of protection.

4.4 Mental Health Act 1983

The Mental Health Act 1983 Mental Health Act 1983 (legislation.gov.uk provides for the assessment, treatment and rights of a person with a mental health disorder. The Act contains the power to detain a person and assess and treat their disorder against their wishes. There are various parts of the Act that can restrict a person's liberty. Relevant to VC's care is the use of Sections 2 and 3 of the Act.

Section 2 of the Mental Health Act allows for a person to be admitted to hospital, for up to 28 days, to assess whether they are suffering from a mental disorder, the type of mental disorder and/or how the person responds to treatment.

Section 3 of the Mental Health Act allows for a person to be admitted to hospital for treatment if their mental disorder is of a nature and/or degree that requires treatment in hospital. In addition, it must be necessary for their health, their safety or for the protection of other people that they receive treatment in hospital. The initial period for which a patient can be detailed is up to six months, but the section 3 can be renewed for a further six months and then annually.

A patient who is admitted to hospital under section 3 MHA can be placed on supervised discharge under a Community Treatment Order (CTO). CTOs are described more fully below. A CTO Is not available where a patient is detained under section 2 at the point of discharge.

In the case of an emergency, the application may be made by the nearest relative of the patient or a medical practitioner under section 4 of the Mental Health Act. Admission via an emergency section will be valid for up to 72 hours with the intention that an assessment will be undertaken during this period to identify whether the

requirements of section 2 or section 3 are met, in which case the section 4 will be converted to the relevant section, either 2 or 3.

Where access needs to be obtained to a patient in their own home (or that of someone else) so that their mental health can be formally assessed, a warrant can be obtained from a magistrate under section 135 of the Mental Health Act. This will allow mental health professionals, usually accompanied by the Police, to gain access to the property and conduct an assessment or remove the person to a place of safety so that the assessment can take place. A place of safety is usually a specially designated part of a hospital.

Section 136 of the MHA allows a police officer to take a person who is deemed to be in public (rather than in someone's property) to a place of place safety if it appears that the person is suffering from mental disorder and is in need of immediate care or control. To further justify the use of this power it must also be necessary to do so in the interests of the person in question or for the protection of others. As with Section 135, the person may be detained at the place of safety for up to 24 hours (with some specific exceptions which extend the period) for the purpose of enabling them to be examined by a registered doctor and interviewed by an Approved Mental Health Professional, and for making any necessary arrangements for their treatment or care. This may include the person being detained under the MHA, admitted to hospital informally with their consent, or being discharged into the community with a plan for their care.

The number of people during 2022 -2023 detained under the Mental Health Act across England were 51, 312. In Nottinghamshire there were two entries which totalled 1,150 recorded detentions, with the highest rate being issued to those identifying as Black. The national average rate of detentions, based on a population of 100,000, was 82.4. Nottinghamshire reported rates from two areas slightly above this average of 99.9 and 101.9, but this rate was significantly less than the highest rate reported as 165.8 in Manchester (GF276 NHS Digital, 2024b).

The Darzi report (2024) Independent investigation of the NHS in England - GOV.UK (www.gov.uk) states that:

> "…there is a substantial evidence base that shows that people from minority backgrounds are more likely to be sectioned under the Mental Health Act…the standardised rate of detention under the Mental Health Act for Black or Black British people was more than 3.5 times higher than the rate for White people…black people are more than ten times as likely as white people to be subject to a community treatment order, where they can be recalled to hospital if they do not comply with treatment protocols."

4.5 Community Treatment Order

Community Treatment Orders (CTOs) were introduced through the 2007 amendments to the Mental Health Act 1983. The Royal College of Psychiatrists reports that their introduction was one of the 'most significant changes to mental health law in the last 20 years. It is also an element which has proved controversial, and both service user and professional groups have voiced strong views about its use.' Community Treatment Orders (rcpsych.ac.uk)

The introduction of the CTO was intended to reduce the admission or duration of stay in a hospital setting and to improve compliance with treatment in the community by making their discharge conditional. If a person does not comply with the conditions of a CTO and there is concern about relapse, the person can be recalled to hospital for a period up to 72 hours. During this period the patient can be assessed and either discharged back into the community under the CTO or formally readmitted to hospital under section 3 by a decision to revoke the CTO.

The criteria for imposing a CTO on a person are contained in section 17A of the MHA and include:

1. The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;

2. It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;

3. Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital;

4. It is necessary that the Responsible Clinician (RC) should be able to exercise the power to recall the patient to hospital; and

5. Appropriate medical treatment is available for the patient

Section 17A of the MHA further makes it clear that, in determining whether a CTO is necessary, the person's responsible clinician *"shall, in particular, consider, having regard to the patient's history of mental disorder and any other relevant factors, what risk there would be of a deterioration of the patient's condition if he were not detained in a hospital (as a result, for example, of his refusing or neglecting to receive the medical treatment he requires for his mental disorder)."*

A CTO can be issued initially for a maximum of 6 months, it can be renewed for a further 6 months and then renewed at 12 monthly intervals. A CTO is not intended to deprive a person of their liberty. However, the CTO will specify the conditions which the person is required to meet whilst it is in place. A CTO will always contain two mandatory conditions including:

- That the patient must be available for medical examinations as required for the purposes of determining whether the CTO should be extended, and

- That the patient should make themselves available to an independent doctor (known as a Second Opinion Appointed Doctor) so that their compulsory community treatment can be assessed and certified as appropriate.

The patient's responsible clinician can add other conditions. These must be necessary or appropriate to ensure that the patient receives medical treatment, or to prevent harm to the patient's health or safety, or to protect others. The responsible clinician and an Approved Mental Health Professional must agree the conditions. The responsible clinician may vary the conditions or suspend them. Common conditions include remaining compliant with medication and attending appointments.

As with all areas of the Act, its guiding principles should inform practice. These are described in the Code of Practice as follows:

- **Least Restrictive Option and Maximising Independence** – wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible.
- **Empowerment and Involvement** – patients should be fully involved in decisions about care, support and treatment. The views of families, carers and others, if appropriate, should be considered when making decisions. Where decisions are taken which are contradictory to views expressed, professionals should explain the reasons for this.
- **Respect and Dignity** – patients, their families and carers should be treated with respect and dignity and listened to by professionals.
- **Purpose and Effectiveness** – decisions about care and treatment should be appropriate to the patient, with clear therapeutic aims, promote recovery and should be performed to current national guidelines and/or current, available best practice guidelines.
- **Efficiency and Equity** – providers, commissioners and other relevant organisations should work together to ensure that the quality of commissioning and provision of mental healthcare services are of high quality and are given equal priority to physical health and social care services. All

relevant services should work together to facilitate timely, safe and supportive discharge from detention. Community Treatment Orders (rcpsych.ac.uk)

Between 2022 to 2023, 5,157 CTOs were issued. A significantly higher rate of these were issued to those categorised within the Black or Black British population (NHS Digital, 2024b). These data were not represented at the regional level and a Care Quality Commission (CQC) report (Mental Health Act community treatments orders (CTO) – focused visits report - Care Quality Commission (cqc.org.uk) recommended in 2022 that NHS Digital should closely monitor and publish this data.

This CQC report was a review of the use of CTOs and focused on their use in 9 London Boroughs (Mental Health Act community treatments orders (CTO) – focused visits report - Care Quality Commission (cqc.org.uk). This was due to concerns around use of CTOs in an 'overly restrictive way' and in response to the draft mental health bill issued by the government in 2022 (Draft Mental Health Bill 2022 - GOV.UK (www.gov.uk)), which states it wants to see a decrease use in CTOs, especially the disproportionate use for Black people.

There appears to be a mixed perspective on the value and current controls in the use of CTOs. The CQC report findings suggest value in avoiding long hospital admissions, carers and relatives perceive them as 'essential' to preventing relapse and facilitate ease of recall to re admission. There also appears to be concern to how the decision is made to apply a CTO, how a CTO is reviewed and removed and ensuring clarity in the nature of restrictions imposed and discretionary conditions.

The CQC heard that CTOs are mainly used for those with a long history of mental health issues, risk or non-engagement and compliance. The power to recall patients was considered to be an effective early intervention to manage the risk of these issues.

The draft Mental Health Bill published in 2022 sets out a series of proposals to reform CTOs and reduce disproportionate use in certain populations. These include:

- strengthening the requirement for evidence and justification for use
- increasing the number of decision makers before someone is put on a CTO, which includes greater involvement of community clinician
- introducing a time limit and increasing the frequency of review
- requiring that CTOs provide a genuine therapeutic benefit to those who are subject to them.

The CQC highlight that it is not clear how the proposals would have the desired impact and acknowledge clinicians and patients express a dislike for aspects of the CTOs, however, families saw them as essential.

4.6 Early intervention in psychosis (EIP)

An EIP service is a multidisciplinary community mental health service that provides treatment and support to people experiencing or at high risk of developing psychosis. This support typically continues for three years and is typically provided to those aged 14-65 years old. An EIP service is built on an ethos of hope and commitment in enabling recovery through the provision of effective, individually tailored, evidence-based interventions and support to service users and their families/carers. eip-guidance.pdf (england.nhs.uk)

There has been recognition of the importance of early intervention treatment strategies for those presenting with psychotic illnesses for some years. A seminal academic paper (O'Connell et al 2022) reports on an international systematic review of the barriers and facilitators to the implementation of Early intervention in Psychosis (EIP) services and factors influential to delivering a standard of care aligned to best practice and guidelines. The authors suggest the characteristics of a EIP service should include:

- early detection
- small patient to staff ratios
- antipsychotic prescribing and monitoring
- provision of psychosocial and behavioural treatments

- 1-3 years duration
- explicit admission criteria
- defined mission to serve specific populations

A summary of the enablers and challenges to the implementation of EIP services are included in Appendix IV. This paper provides context for the investigation findings. Key themes suggested as influential to the effectiveness of EIP services include: effective leadership and governance structures, level of political interest, resources, size of caseloads. O'Connell et al consider that the healthcare landscape will influence the implementation of EIP services and this may be improved through political will, legislative change and the design and organisation of services and resources. They conclude that there is a need to better understand the implementation gap around EIP services.

4.7 Crisis Resolution and Home Treatment (CRHT) or Crisis team

Within this report there is reference to both a CRHT team and a Crisis team. Our understanding is that the terms were used interchangeably to describe the same service. Therefore, a CRHT (Crisis) service provides a 24 hour, seven day crisis resolution service that offers assessments to people with significant mental illness who would otherwise be admitted to hospital. Generally, the CRHT service is for men and women aged between 18 and 65.

The CRHT team can offer short term home treatment to try to reduce the risk of an individual being admitted to hospital and providing support to achieve recovery from crisis at home. A CRHT team is usually made up of a range of healthcare professionals including:

- Doctors
- Nurses
- Occupational therapists
- Support workers
- Non-medical prescribers

4.8 Delivery of guidelines

4.8.1 National Guidelines for England

Various national bodies develop and publish guidelines, including Royal Colleges, NHS England and the National Institute for Health and Care Excellence. From a regulatory perspective, the Care Quality Commission.

The National Institute for Health and Care Excellence (NICE) provides national guidelines intended to improve early identification treatment and care to help and support psychosis and schizophrenia in adults (NICE CG178, 2014). They highlight that although the emphasis has been placed upon early diagnosis, early intervention and promoting a person's choice on management to support long term recovery, not everyone will accept support.

These guidelines outline expectations on the prevention, treatment (medication and therapeutic), monitoring and support for long term recovery and integration back into the workplace or education. The options for type and form of delivery of medications are outlined within these guidelines, with a note to consider each 'service user's preferences' for some forms of delivery, for example, tablet vs injectable long-acting medication (depot). Non-compliance with medication regimes 'because of adverse effects or lack of efficacy' and alternative approaches to treatment is suggested as relevant for a 'high proportion' of people with a psychotic disorder.

The guidelines require practitioners to be knowledgeable and responsive to cultural differences when delivering information, care or treatment for people with psychotic disorders.

> 'Mental health services should work with local voluntary black, Asian and minority ethnic groups to jointly ensure that culturally appropriate psychological and psychosocial treatment, consistent with this guideline and delivered by competent practitioners, is provided to people from diverse ethnic and cultural backgrounds. [2009]' ((NICE CG178 – 1.1.2.3, 2014).

These guidelines extend to the support that should be offered to close relatives or friends to ensure accessible information is provided around the condition, services and how to get help in the context of a crisis.

NICE guidelines stress the need for expertise of professionals experienced working transculturally. This includes:

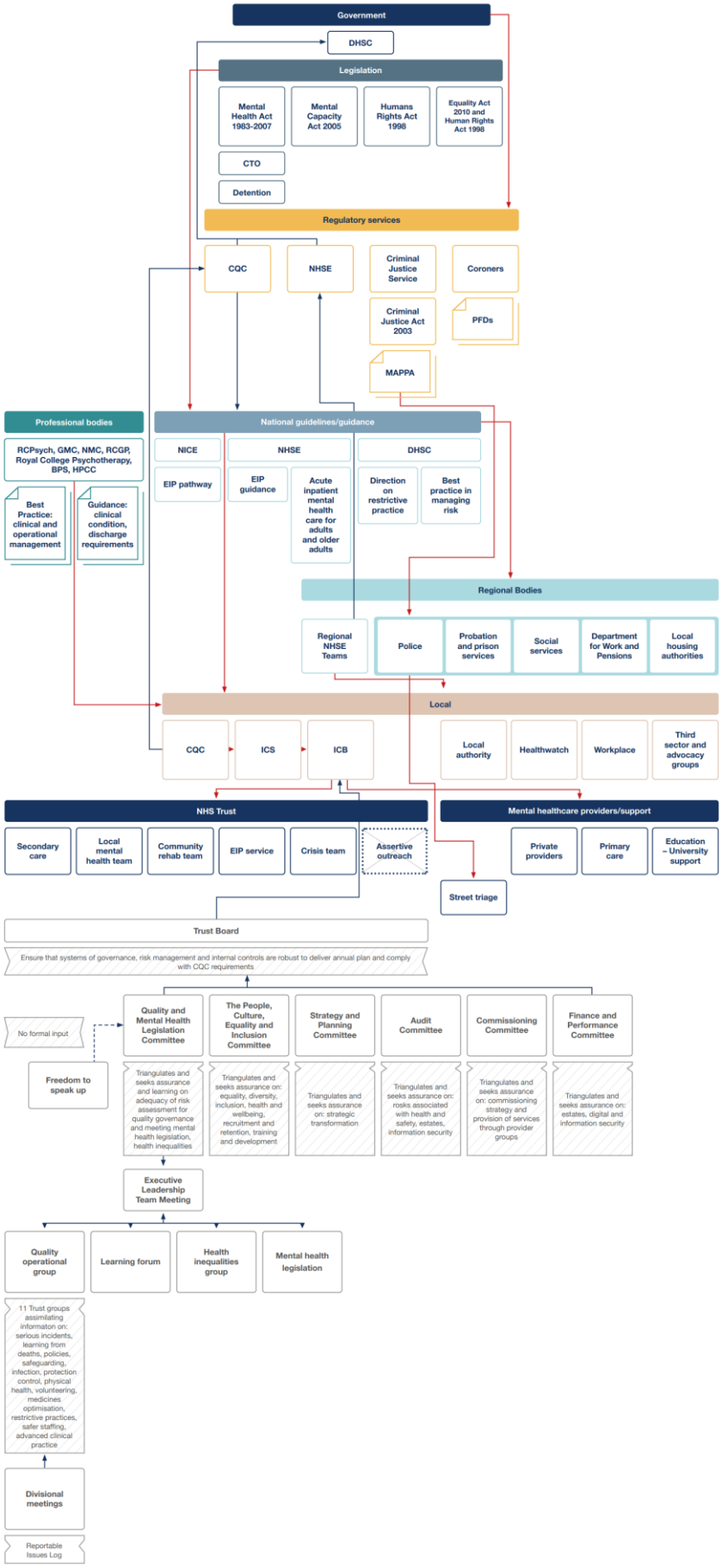
- assessment skills for people from diverse ethnic and cultural backgrounds
- using explanatory models of illness for people from diverse ethnic and cultural backgrounds
- explaining the causes of psychosis or schizophrenia and treatment options
- addressing cultural and ethnic differences in treatment expectations and adherence
- addressing cultural and ethnic differences in beliefs regarding biological, social and family influences on the causes of abnormal mental states
- negotiating skills for working with families of people with psychosis or schizophrenia
- conflict management and conflict resolution. NICE CG178 [2009]

Recognition that peer support provided by someone with lived experience who has recovered or is in a stable state from their own condition may improve the quality of life and experience of people with a psychotic disorder. This is considered as a positive aspect of a wider self-management programme.

4.9 Mental health care system

This diagram outlines key structures and organisations that are considered relevant to the independent investigation. The diagram is intended to illustrate lines of control (red arrows) of these different structures and the Table in Appendix V describes the core functions at each point of the system. The diagram also visualises where the investigation believed there was a mechanism for reporting and providing feedback (blue arrows) back up the system.

Organisational structures relevant to delivery of mental health services in the context of the independent investigation



The investigation describes the findings which consider whether there is an appropriate level of insight from policy makers as to how legislation and resources impact the risk created for frontline staff to absorb. The information that informs the feedback appears heavily driven by performance metrics from the top of the system, which has changed over the years and may not reflect data that provides indicators that impact the effectiveness of services such as the EIP service. The data required for feedback appears to be driven by financial investments to understand if expected spends are delivering core mental health services.

4.10 Context of mental health services in England

Research led by the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) at King's College London and commissioned by Mind warned that public attitudes to mental health have seen their first decline in over 10 years. Attitudes to mental health have dropped to 2014 levels, driven by declining attitudes to community-based care. A complex picture shows that while decreases in prejudice achieved in the past fifteen years have been maintained, there is declining faith in the suitability and efficacy of care for people with mental health problems in communities. Public attitudes to mental health decline for the first time in 10 years | King's College London (kcl.ac.uk)

There has been a recognition, and a national approach aimed to increase the equity in the management and treatment of physical and mental health conditions for over a decade (Garrant, 2023).

In September 2024 an independent investigation of the National Health Service in England by the Rt Hon. Professor Lord Darzi was published.

This investigation found that the need for mental health services has grown rapidly. In 2016, around 2.6 million people were in contact with mental health services; by 2024, this had increased to 3.6 million people.

An increased demand for services is echoed in the CQC report, The state of health care and adult social care in England 2022/23[5] which states that access to and quality of mental health care remain key areas of concern. Gaps in community care are continuing to put pressure on mental health inpatient services and many inpatient services are struggling to provide beds for those assessed as needing inpatient care.

Despite the increased need, the overall mental health workforce reduced by 9.4 per cent between 2010-11 and 2016-17. The number of mental health nurses decreased by 13 per cent between 2009-10 and 2016-17. Between the start of 2017-18 and the end of 2023-24 the workforce then expanded by 26.5 per cent. But the number of mental health nurses only returned to their 2009-10 level between 2023-24. NHS Digital data describes current regional staff vacancies. The total Mental health staff workforce vacancy rate (2024) was 13.2%, the highest since the data were collected in 2018 (NHS, 2023b).

A commitment for resources to support this work has been ongoing since 2016 (Five Year Forward View for Mental Health, 2016). The plans outlined within the NHS Long Term Plan are to increase resources, finance, staff, research and to increase the level of integration across relevant services (NHS Long Term Plan 2019).

The implementation of these improvements is outlined within the Community and mental health framework for adults and older adults (NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019). This document is the product of a collaboration between professionals, voluntary sector, communities and those with lived experience. The document focuses on the integration of key services and providers at a local level 'that promote cross-professional and organisational safety and learning approaches' (p15).

[5] 20231030_stateofcare2223_print.pdf (cqc.org.uk)

In 2021-2022 the NHS spent approximately 12.0 billion on mental health services and the National Audit Office (February 2023), evaluated the value and implementation of NHS commitment outlined in 2016 (National Audit Office, 2023). The report highlights the absence of standards to enable a judgement on how far the NHS has moved towards equity and improvement of mental health services. The report evidences a gradual increase in spending in mental health services, although raises the issue of poor-quality baseline data, which makes it difficult to 'quantify any historical under-funding' and the actual costs of complex commissioning arrangements. However, based on the available data the report by the National Audit Office concludes that with the current level of funding and staff, the NHS would not be able to provide the level of care to all those with mental health conditions.

The aspiration for the integration of mental health services was visualised in the image below (NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019). It acknowledges that meeting the needs for those with mental health concerns stretches much wider than the healthcare system.

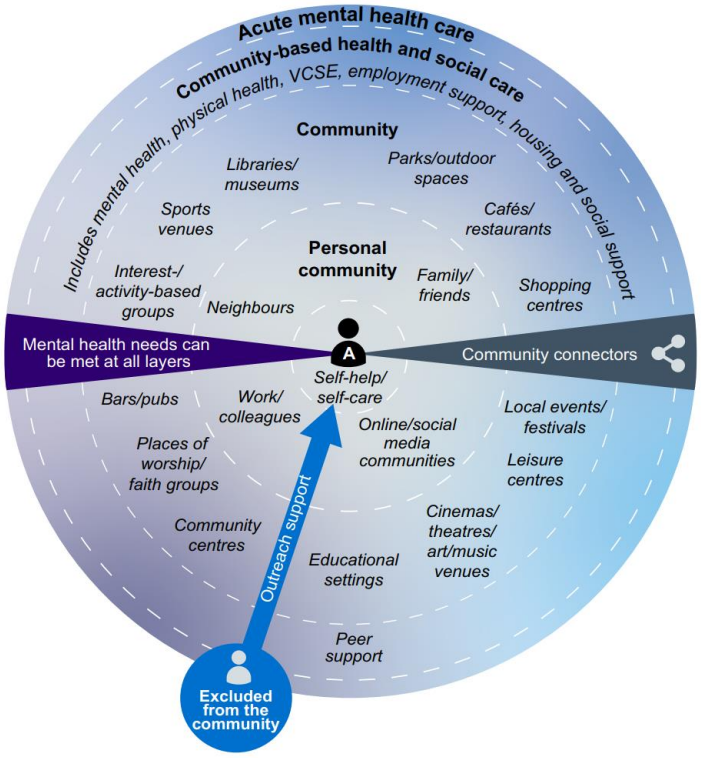


Figure 2 NHS England's vision for the integration of mental health services (2019)

A plan for the implementation of the vision for integration and new structures for mental health services between 2019 and 2023 was outlined (NHS England and NHS Improvement and the National Collaborating Centre for Mental Health, 2019). This included the intention to provide additional funding for community and primary care, with regional commissioning groups collaborating with stakeholders, representative of providers and social and public representatives. Integration and governance across services (primary, secondary, social care, voluntary and community services), being at the centre of the intended implementation plan. Local commissioners and care providers were directed towards a number of national documents and promised implementation support to test new models of care.

The NHS Long Term Plan has a strong focus on expanding and improving the quality of community care for people with mental health problems, including people with a learning disability and autistic people. More people are accessing community mental health services than ever before and the plan reiterates the commitment to ensure people can access timely, high-quality community support, closer to their families and loved ones. NHS England » Mental Health, Learning Disability and Autism Inpatient Quality Transformation programme. The community mental health transformation Programme has been co-designed with service users and carers nationally in association with the National Collaborating Centre for Mental Health. The programme has five objectives:

1. Localising and realigning inpatient services, harnessing the potential of people and communities
2. Improving culture and supporting staff
3. Supporting systems and providers facing immediate challenges
4. Reducing restrictive practice through least coercive care
5. Measuring success

The above objectives are being met by a series of transformation programmes such as the Culture of Care programme which aims to improve the culture of inpatient

mental health, learning disability and autism wards for patients and staff so that they are safe, therapeutic and equitable places to be cared for, and fulfilling places to work Culture of Care Programme (rcpsych.ac.uk)

4.11 Get It Right First Time (GIRFT) Report

GIRFT is a national NHS England programme of work that seeks to provide a national review of care delivered and seeks to capture best practices to share with the aspiration of reducing variability in the quality and cost of care in England. Their report into mental health (GIRFT, 2021) highlights that historically, mental health services relied heavily upon inpatient settings but is now overwhelmingly a community based service. This report goes on to confirm that the community services remain underequipped as they are under resourced and that inpatient care is not always delivered locally or in the time required.

This report acknowledges there are considerable interactions and dependencies across the mental health service. For example, well-managed flow between different services, which impacts the capacity and ability to achieve the desired outcomes in delivering different levels of mental health care and treatment.

4.12 Mental health and the impact of COVID-19

Research found that the groups most at risk of adverse mental health outcomes during the pandemic included young adults, women, those with pre-existing mental health conditions, those from minority ethnic communities, and people experiencing socio-economic disadvantage. Many of these characteristics may overlap. People with these characteristics may already have been at higher risk of some adverse mental health outcomes before March 2020; the pandemic exacerbated these health inequalities. POST-PN-0648.pdf (parliament.uk)

4.13 Mental health within the context of the criminal justice system (CJS)

Around a third of people who find themselves in police custody have some form of mental health difficulty, as do 48 per cent of men and 70 per cent of women in

prison. Entry into the CJS can provide a chance for people who have been missed by other services to access mental health treatment. Additionally, mental illness and the associated symptoms can trigger criminal behaviour bringing a person into contact with the CJS. Decisions then need to be made on whether a criminal charge is in the public interest or whether an alternative disposal (such as diversion into mental health treatment) would be more appropriate. Mental illness can affect an individual's ability to understand and participate in the criminal justice process. It is also important to recognise that the experience of the criminal justice process itself, can have a severe and negative impact on someone's mental health, particularly if they already have a mental illness. A joint thematic inspection of the criminal justice journey for individuals with mental health needs and disorders (justiceinspectorates.gov.uk)

Contextual facts

Mental health in the criminal justice system: key facts

Police	
159	Number of detentions in England and Wales under section 136 of the *Mental Health Act 1983*, where a police station was used as a place of safety, 2019/2020[1]
29%	Percentage of those in police custody identified as having a current mental illness[2]
Liaison and diversion	
71%	Percentage of those referred to a liaison and diversion scheme who had a mental health need[3]
Courts	
1%	Percentage of all requirements commenced under community orders and suspended sentence orders that were Mental Health Treatment Requirements, England and Wales, 2020[4]
Prison	
52%	Percentage of prisoners with self-reported mental health problems during the pandemic[5]
22%	Percentage of prisoners who responded that it was easy to see mental health workers during the pandemic[6]
691	Number of self-harm incidents per 1,000 prisoners in 2020[7]
67	Number of self-inflicted deaths in prison, 2020[8]
Probation	
36%	Percentage of inspected probation cases (2018/2019) where mental health needs and disorders were identified as a disability[9]
38%	Percentage of inspected probation cases (2016/2017) where emotional wellbeing was identified as a priority need[10]

The diagram above provides the contextual facts for those with mental illness in the criminal justice system.

The Criminal Justice Joint Inspection (CJJI) body reported that thousands of people with a mental illness are entering the criminal justice system each year with their needs being missed at every stage. It also described a 'broken system' for the sharing of information between agencies, with incomplete/inaccurate records. A shortage of services with long delays to access those available, compounded by the impact of the pandemic. 'Unacceptable delays' in psychiatric reports for court and in transferring extremely unwell prisoners into secure mental health hospital beds for treatment. [Criminal justice system failing people with mental health issues – with not enough progress over the past 12 years (justiceinspectorates.gov.uk)]

Consideration of the impact of race and the likelihood of mental health issues and contact with the criminal justice system suggests Black, Asian and minority ethnic communities are at a higher risk of mental illness and are disproportionately represented within the criminal justice system (Nacro, Clinks, the Association of Mental Health Providers and the Race Equality Foundation, 2017)

In 2021 a review carried out by Her Majesty's Inspectorate of Probation examined the experience of those with mental health issues within the CJS. The review found that there was a lack of progress over the past12 years in respect of how the CJS dealt with offenders with mental health issues. In particular it noted a lack of reporting and tracking of those with mental health issues through the CJS and poor use of definitions on mental health conditions by the CJS.

The review also identified that the poor sharing of information across agencies involved has not improved over the past 12 years. It highlighted barriers created between community mental health services and the CJS as staff seek to adhere to data privacy policies which impeded sharing of critical information. This review included a recommendation to develop a multi-agency memorandum of understanding between the Ministry of Justice and the Department of Health and Social Care on information sharing to support the communication and joint working across these areas.

The review did find reliability across the police forces reviewed that risk assessment during police custody work was taken seriously and completed with a level of consistency. However, it noted that the recording and identification of existing information relevant to a suspect's mental health was missed or not acted upon. The review concluded that this was due to 'human error' rather than challenges highlighted within the report of the technical systems, large number and ease of tracking information relevant to previous mental health issues (Her Majesty's Inspectorate of Probation, 2021, p58-59).

4.14 Background to Mental health care in Nottinghamshire

Nottinghamshire Healthcare NHS Foundation Trust (the Trust) is one of the largest mental health and community Trusts in the East Midlands and one of the biggest employers in Nottinghamshire. They provide care to more than two million people a year with an annual budget of £628m. The Trust employs over 11,000 people who provide intellectual disability, mental health, community health, forensic and offender healthcare services across Nottinghamshire, Leicestershire, Lincolnshire and South Yorkshire. Services are delivered from over 257 locations within the community from acute settings and across low, medium and high secure environments including prisons.

4.15 Finances

Nottingham City published their strategy for 2019 – 2023. In the opening Forward of this document the system's capacity to manage the scale of mental health problems is stated.

> 'Currently, and for the foreseeable future, Nottingham City faces substantial challenges that impact upon mental health including higher levels of deprivation, child poverty, unemployment, a population living longer with more ill health and greater levels of physical and mental health co-morbidities. This challenge is further accentuated by the fact that there are fewer financial resources available to public and voluntary sector organisations enabling us to respond to the level of need.'

4.16 Performance metrics

The national dashboard produced by NHS England reflects the period of time that is the focus of this investigation and suggests the Trust performance for certain performance indicators was below average. Specifically highlighted is the metric relating to the provision of Early Intervention Psychosis (EIP) services (Figure 4-,

NHS England 2023a). Whilst acknowledging the improvement from 2022 to 2023, however, the provision of this service remained below the national average.

The Trust provided the independent investigation with their results of the National Clinical Audit of Psychosis undertaken by the Royal College of Psychiatrist. The results for 2024 demonstrate that they are now assessed to be 'top performing' overall across a range of measures.

A metric was introduced to evaluate the performance of crisis teams and their ability to respond to urgent requests within 24 hours and very urgent requests within 4 hours. The data indicates that the 'within 4 hours' is being met between 75% and 94% of the time and within 24 hours between 66% and 81% of the time.

4.17 Care Quality Commission review of Trust

The Care Quality Commission (CQC) grades care providers against each of the five key questions below:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive to people's needs?
- Is the service well-led?

Each of these questions is rated according to a four-point scale. Outstanding, Good, Requires Improvement, Inadequate. The ratings for each of these questions are then aggregated to form an overall rating.

The Trust's overall CQC ratings are currently suspended whilst the CQC investigates concerns about the provider. However, during a March 2024 inspection the CQC visited three mental health services and the overall rating for the services inspected

went down to requires improvement. They also inspected four community health services – three remained as ‘good’ and the other remained as ‘requires improvement’.

At this inspection the overall ratings for mental health services stayed the same in the domains of ‘safe’ and ‘responsive’, which they rated as ‘requires improvement’. Caring stayed the same, rated as ‘good’. The ratings for ‘effective’ and ‘responsive’ went down to ‘requires improvement’.

The rating for well-led in mental health services, remained the same as ‘requires improvement’. At this inspection the overall well-led provider rating remained as ‘requires improvement’. Nottinghamshire Healthcare NHS Foundation Trust - Care Quality Commission (cqc.org.uk)

Following VC’s conviction, the Secretary of State for Health and Social Care commissioned the CQC to carry out a rapid review of the Trust under section 48 of the Health and Social Care Act 2008. The findings were published on 26 March 2024 and identified 3 enduring areas of concern at the Trust:

- mismatch in demand for services and access to care,
- inadequate staffing,
- leadership issues.

The CQC published the second part of their special review on 13 August 2024. This part of the review looked specifically at the care and treatment provided to VC and also benchmarked the care of 10 other patients on the EIP pathway. The review identified concerns with:

- assessing and managing risk in the community,
- the quality of care planning, and the engagement and involvement of families,
- poor quality of discharge planning.

Further CQC reviews and inspections that that have taken place at the Trust include:

- Community mental health services with learning disabilities or autism, published 24 May 2019
- Rampton Hospital, published 8 June 2018
- Rampton Hospital, published 15 June 2017

In the March 2024 report, in relation to Rampton High Secure Hospital the CQC reported:

> 'We have had ongoing concerns about the quality of care at Rampton Hospital for nearly 5 years. Since July 2019 we have inspected the hospital 5 times, the last of which was in June 2023. During this time the hospital has not received a rating above requires improvement. While care at Rampton Hospital has improved since our previous inspections, we continue to have concerns in a number of areas.' These were documented as:

- Poor communication between staff and patients
- Safety of patients had improved, but issues around the prescribing of medicines and monitoring of people's physical health meant that people were not always being kept safe
- Staffing levels had improved but they did not always meet the needs of patients on the wards. Despite confinement being used less, this was still part of the culture of a small number of staff in the hospital
- Leaders had addressed many of the issues identified on our previous inspections and recognised ongoing concerns with the culture need to be scrutinised.

4.18 Trust's thematic homicide review

In August 2024, an independent thematic report was produced into a number of homicides which were committed by individuals who had contact with the Trust's mental health services between 2019 and 2023. Seven reports were identified as meeting the criteria for inclusion of the review (5 homicides and 2 attempted homicides). This review included consideration of the homicide committed by VC in June 2023. There were three further reports which had not yet been completed

which fell within the timeframe. The emerging themes that were identified in the report are contained within the oversight and assurance section of this report.

5 Chronology of VC's engagement with mental health services

5.1 Care and treatment

5.1.1 Before contact with mental health services 1991 - 2020

VC was born in September 1991 in Guinea Bissau (West Africa). He moved with his family to Portugal at the age of seven. When VC was 16, he moved to Wales, UK with his parents, and his younger brother and sister. He left school in 2011 and worked as a labourer or cleaner. He then moved to Birmingham and undertook a Higher Education course and subsequently gained a place to study a mechanical engineering Master's degree at Nottingham University which he commenced in 2017 and was due to complete in 2021. VC first become acutely unwell in 2020, which impacted his ability to study and resulted in him having to resit a number of his final 3rd-year exams. He was subsequently due to complete the final Master's year of his course in 2020/21. However, because of the difficulties he was experiencing with his mental health, VC found it increasingly difficult to attend and to complete the required coursework. VC tried again in 2021/22 to complete the Master's element of his degree, However, with ongoing psychotic symptoms he found this extremely difficult, so it was agreed with the university for VC to graduate with a Bachelor's degree with the work he had completed in 2020. He subsequently obtained a class 2:1 degree in June 2022.

5.1.2 First presentation to mental health services

On 24 May 2020, at the age of 28, VC was arrested for criminal damage to a neighbour's flat. He was assessed by a nurse from the Mental Health Liaison and Diversion Service in Bridewell Police Custody suite. The documented impression was that VC was experiencing a first episode of psychosis brought on by sleep deprivation and social stressors, (course work and upcoming exam).

A Mental Health Act assessment was undertaken but given that VC said that he acknowledged that he was unwell and that he needed help, he was not detained under the Mental Health Act. He was referred to the City Crisis Team and medication (Olanzapine 2.5 mgs at night and Zopiclone 7.5 mgs at night) was prescribed. Olanzapine is an antipsychotic medication that helps to manage symptoms of mental health conditions such as schizophrenia. Zopiclone is a type of sleeping pill that can

be taken for short-term treatment of severe insomnia. This medication was not administered before VC was released from the Police Custody Suite. VC's family asked if he could be held until they arrived to take him home with them, such was their concern as they were travelling to Nottingham from Wales to collect him. However, the police had no legal grounds to continue to detain VC.

VC told the independent investigation that he could hear voices of family members coming from the flat and therefore he entered the flat. The neighbour was reportedly frightened and jumped out of the first-floor window, resulting in injuries requiring hospital treatment. VC was arrested. He was not considered to have the capacity to consent to hospital admission and was therefore detained in hospital under section 2 of the Mental Health Act, following assessment at the police station. He was assessed and documented as being a risk to himself and others and was described as distracted and actively psychotic.

VC's mother rang a nurse within the Mental Health Liaison and Diversion Service (MHLDS) at the Police Station who was unable to give VC's mother information as VC had not given consent. The Mental Health Act assessment documented that VC's parents stated that his behaviour was completely out of character.

5.1.3 First inpatient admission 25 May 2020 – 17 June 2020

On initial medical assessment following admission to hospital, VC was described as preoccupied, apparently not recalling what had happened in the Police Station. He was also described as responding to unseen stimuli and was very suspicious of all clinicians, refusing initially to speak to the doctor and have any physical examination.

Contact was made by VC's mother on 26 May 2020 and staff obtained consent from VC to share information with his mother. She engaged with staff giving an account of his presentation over recent weeks as well as describing what he was usually like.

On the same day, VC was documented as being unsettled in the ward corridor and was kicking doors. Lorazepam 2 mg PRN (which is a medicine prescribed to be given as needed) was administered intramuscularly under restraint. At that point VC was saying he wanted to leave the ward and on one occasion he appeared to try to break out of the ward main door.

At a Ward Review on the 28 May 2020, the Responsible Consultant explained to VC that he appeared to be having a psychotic episode, most likely linked to sleep deprivation and stress. A period of assessment whilst VC was free of psychotropic medication was suggested (although PRN medication remained prescribed). VC engaged with the ward review, appearing to acknowledge that his behaviour had been out of character.

VC's Consultant spoke to his mother on the 1 June 2020 updating her on VC's presentation and informing her that his mental state appeared to be improving. She told the ward that she had contacted the university and had also made contact with the mental health liaison team at the university. A face-to-face visit by VC's mother was agreed during that conversation.

VC was assessed by the Occupational Therapy (OT) team on 3 June 2020. Attempts were made to engage him in more formal assessment, but he declined. However, he did share his views about feeling stressed with university work and his poor sleep routine. VC declined ongoing OT input, but the plan was for OT to remain in contact with him and offer support if he accepted it. Also on that date, VCs brother shared information from text messages between him and VC between late March and late May 2020, with his treating consultant to assist with their evidence base.

VC's clinical records summarise his presentation as demonstrating 'clear evidence of auditory hallucinations 3rd person, passivity and persecutory delusional beliefs. This

suggests more of a functional illness[6] rather than it being precipitated by stress or isolation.'

VC's clinical records suggest that on 4 June 2020, his consultant spoke with the university mental health liaison officer who advised that it was better for VC not to return to his flat upon discharge and instead to return to his mother's accommodation in Wales where he could continue his studies online and then take the exam during the resit period in the summer. VC expressed that it was not his preference to return to Wales and instead discussed moving back to Birmingham, where he had lived before attending university. By way of context, in June 2020, during the first national lockdown in response to the COVID-19 pandemic, many students across the country chose to move home and leave their term-time accommodation early when teaching moved on-line Coronavirus: Student accommodation issues - House of Commons Library (parliament.uk)

On 5 June, 2020, it is documented that VC was observed pacing through the ward and that he reported he could hear a woman in distress and wanted to save her. VC believed the voice was coming from the linen cupboard and was surprised when the nurse opened it and there was only linen inside.

Later that day, the treating consultant met with VC and his family. The consultant's documented clinical opinion was that VC was suffering from a first episode of psychosis that would require treatment. VC was described as accepting of the need to start medication. It was explained that his consultant would commence VC on Aripiprazole[7] later that day.

[6] A functional illness is one where no organic reason can be found for the symptoms. This term is often used for mood, anxiety disorders and schizophrenia.
[7] Aripiprazole is an antipsychotic medicine that works by affecting chemicals in the brain such as dopamine and serotonin. It does not cure the condition, but it can help with the symptoms. It is used in conditions such as Schizophrenia.

Over the next week VC was predominantly described as maintaining a low profile, often remaining in his bedroom. During a team discussion on 8 June 2020 VC was documented as: 'mainly remained in bed space, unclear why this is, has declined all OT input, some concerns he is not eating regularly, overall seems polite, posing no management problems but seems increasingly withdrawn, need to uncover why this may be e.g. is he masking psychosis or low mood or are there other reasons. Was reported to have been hearing a woman's voice screaming which staff could not hear.'

VC's family told the independent investigation that on 10 June 2020 VC's mother called the ward to express her concern that the planned discharge date was too early as VC appeared paranoid. VC's mother was hoping to speak to the responsible clinician the next day but was not able to do so. This call is also recorded in VC's clinical notes for that day. The treating Consultant spoke with VC's mother on 12 June 2020 and it is documented that the plan for VC's discharge was discussed during this call.

On the 15 June 2020, the Ward Manager, treating Consultant, Ward Doctor and a Registered Mental Health Nurse (RMN) met with the Crisis team[8] to discuss discharge planning. At this point VC was documented as presenting as stable on the ward. It was documented that it now seemed more likely that VC was experiencing an ongoing illness. It was noted that there did not appear to be risks associated with VC returning to his flat in Nottingham because his presentation was considered to be much improved, and he was not considered to have any issues with alcohol or illicit substances although no drug testing took place. At this point VC was talking about wanting to move back to Birmingham, where he had lived before university.

On 17 June 2020, VC was reviewed, and his mother was recorded in the notes as being present. It is documented that staff answered questions about VC's

[8] The Crisis team, also known as the Crisis Resolution and Home Treatment (CRHT) Team is described in the introduction of this report. However, in relation to this aspect of care, the Crisis team can assist with the early discharge from hospital by providing intensive support to an individual in their own home.

presentation, diagnosis of first episode psychosis and explained why there was no specific label used and how this was not useful at this time. A plan was made for VC to be discharged that day. In summary, the plan was:

1. Discharge VC from hospital and Mental Health Act section rescinded.
2. Continue his medication for at least 6 to 9 months minimum and encourage VC to seek medical advice if he wishes to stop.
3. Have a follow-up with the Crisis team – a 3 day follow up was planned for 18/06/2020.
4. The Crisis team were aware that they will continue to provide regular follow up until VC has decided where he is going to stay and then pass on his care to the respective EIP service.
5. 14 days of prescription medication to take home (TTO's) given to VC and VC told to get further supplies from his GP. (Aripiprazole 5mg OD).

5.1.4 First episode of community care 17 June 2020 – 13 July 2020

On 18 June 2020, VC received a 3-day post-discharge from hospital follow up by phone (it was a call rather than face to face because of COVID-19 restrictions at that time). However, VC's family consider it would have been beneficial seeing VC face to face as he was still paranoid on leaving hospital and this would have enabled a more thorough assessment particularly given that VC's family felt that he was able to play down his symptoms on the phone.

VC reported feeling well and confirmed that he had been given 14 days' worth of medication. He denied any acute mental health symptoms and was documented as recognising he was poorly prior to his admission and was pleased he was admitted.

VC's family told the independent investigation that they emailed VC's treating consultant from the ward on 19 June 2020 to question whether it was right that VC was being managed through phone calls rather than face to face appointments.

The UK was still in the first lockdown at this point and therefore a lot of contact had moved to telephone, where it was felt appropriate to do so. During this period, face to face appointments were not prohibited and they could take place if it was deemed that they were necessary.

On 22 June 2020, VC's inpatient consultant emailed the Crisis team asking that VC be seen face to face in order to better gauge his mental state as there was a risk he would downplay any symptoms or problems he was experiencing. He was subsequently seen at home the following day by the Crisis team. Due to VC planning to remain in Nottingham, it was agreed that he would be referred to the local EIP team. It was documented that VC had the ability to mask his psychotic symptoms and that he had a history of violence and aggression when his mental health deteriorated. It was considered that there was a further risk of deterioration in his mental state if he was non concordant with medication.

VC reported to a Crisis worker during a telephone call on 26 June 2020 that his voices were "dying down".

On 30 June 2020, a joint home visit between EIP and the Crisis team took place. VC was given verbal and written information on the EIP service, psychosis and recovery. It was documented that VC presented as a bit distracted with delayed responses, but he denied experiencing any auditory hallucinations. He described himself as happy to continue taking medication. He was subsequently discharged from the Crisis team to the EIP team.

The next contact took place on 3 July 2020 when VC's care coordinator (Care Coordinator 1) telephoned him to enquire about medication. VC told them that he did not have any medication left but had not contacted his GP regarding this. It was therefore agreed that the EIP would take over prescribing and medication would be delivered the same day. Four weeks supply of 5mgs Aripiprazole was subsequently taken to his accommodation.

On 11 July 2020 VC's mother contacted the mental health service as she was concerned about VC's mental state. She spoke to a nurse and described having spoken to her son on the phone regularly and having concerns that he may not be taking his medication as prescribed. She did ask that VC not to be made aware that she was asking about his care because she was worried about losing his trust.

On 13 July 2020, Care Coordinator 1 tried to contact VC's mother to discuss the concerns that VC's mother had raised to the service two days earlier about VC's mental state. VC's mother was unable to answer the phone on this occasion but this investigation notes that she had shared her concerns during the call with a nurse in the EIP on 11 July.

5.1.5 Second inpatient admission 14 July 2020 – 31 July 2020

On 13 July 2020, the Police were contacted by VC's neighbours. VC had been banging on a neighbour's door and when someone opened it, he immediately forced his way in, attempting to push past the resident. He was restrained on the floor by a number of residents until Police arrived. One of the Officers had dealt with the previous incident where VC forced his way into someone's property in May 2020, and therefore asked Street Triage[9] to attend. The Street Triage assessment documents state that the nurse "got the impression that [VC] was attempting to conceal his symptoms". The notes also document that following discussion with the Police it was evident that VC could not return to his address, due to the risk of similar incidents based on recent history. It was noted that custody did not seem to be an appropriate place based on the likelihood that this presentation was driven by VC's mental health. VC was placed on

[9] This team is a partnership between the Healthcare Trust, the Police and local CCGs (Clinical Commissioning Groups). It joins up mental health practitioners with Police Officers to provide a specialist response to people with mental health issues. They signpost patients to the appropriate service.

a Section 136[10] to safeguard himself and others and was subsequently conveyed to the 136 Suite[11].

VC's mother was contacted to inform her that VC had been detained. The family told the independent investigation that they were not surprised by this given they had flagged concerns about VC's deteriorating mental health on 11 July 2020. It is documented in the clinical records that VC's mother reported that she was unsure whether VC had been taking his medication despite calling him every day to prompt him. She believed he may have been masking some of his symptoms and denying that he was experiencing any auditory hallucinations.

On the same day, a Mental Health Assessment took place. It is documented in the clinical records that it was clear from the assessment that VC had decided to stop taking his medication 2 weeks after his last discharge from hospital. VC believed that he was well, he did not have mental health problems, and he would be fine. It is documented that he started to hear voices two weeks ago and the voices were in the 3rd person and for the most part were derogatory in nature. He was convinced this was the doing of his next-door neighbour and went to confront him. He was unclear how this person was able to do this. The notes document that VC minimised the potential risk to others and that he did not fully acknowledge the risks of his action to others even though when this had happened prior to his last admission the affected person had jumped from the first floor in fear and in the process injured their back and needed surgery.

It is documented that during the assessment VC 'said the right things, that he had made a mistake not taking his meds, he would now take them, but he still was not

[10] Section 136 gives the police the power to remove a person from a public place, when they appear to be suffering from a mental disorder, to a place of safety. The person will be deemed by the Police to be in immediate need of care and control as their behaviour is of concern. A person is not under arrest when the decision is made to remove the person to a place of safety. The Police power is to facilitate assessment of their health and wellbeing as well as the safety of other people around them.
[11] A 136 Suite is a hospital facility for people who are detained by the Police under Section 136 of the Mental Health Act. It provides a 'place of safety' whilst potential mental health needs are assessed under the Mental Health Act and any necessary arrangements made for on-going care.

convinced that he was unwell nor did he feel he needed to be in hospital.' The notes go on to say VC's 'insight was poor, and this makes him vulnerable to ongoing relapse and risk to others.' The notes conclude that VC was in need of treatment, risk management based on what has happened and he needed to work on his concordance and insight, which was currently only possible in hospital. He was not suitable for community treatment at that time.

The plan was documented as-

1. VC needs to be in hospital and since he was not willing to come into hospital voluntarily, he was detained on section 3.
2. VC needs to re-start his medication - Aripiprazole 10mg OD immediately.

VC was then transferred to a ward.
On 16 July 2020 a 72-hour ward review took place.

In terms of 'risk to others', it was documented that VC 'believed others were trying to spy on him/torment his mind and tried to enter a neighbour's flat to confront them, there have been no incidents of violence yet, but this would be a potential concern if acutely unwell.'

Under 'patient comments' which is a summary of the discussion recorded by the junior doctor it states that: '[VC] describes stopping medication two weeks after discharge from his last admission because he read that it could 'slow the mind'. He concedes that doing so may have 'made me a little more paranoid'. Seems non plussed when confronted with the effects of his behaviour with the neighbour during this incident and also the previous admission. No signs of remorse or insight into how his actions have affected others. Just says 'there will not be a next time'. [the ward consultant psychiatrist] observed that there seems to be no insight or remorse, and that the danger is that this will happen again and perhaps [VC] will end up killing someone. [VC] simply responds by saying 'it will not happen again'. The doctor documented that the Police are not intending to press charges.

The treating consultant described in the clinical records the view that it was increasingly likely that VC had schizophrenia although VC did not appear to fully accept this. Depot medication was discussed as it appeared that he was not taking medication following his previous discharge from hospital. The pros and cons of depot were discussed with VC, and it was agreed that the ward staff would provide further information for him to consider. VC's family told the independent investigation that they were concerned that the decision about depot medication largely appeared to be left for VC to decide whether he wanted to take medication that way. On the one hand this gave VC the opportunity to decide how he received his medication yet in the same assessment it was documented that VC did not have the capacity to make decisions about admission and or treatment.

On 18 July 2020 a phone call took place with VC's mother, information was shared (with VCs consent) and VCs mother asked that she be included in VC's reviews and discharge planning.

On 20 July 2020 VC had a session with an Acute Psychological Interventions Practitioner (who was a nurse specialist) where they discussed the recent deterioration in his mental health and the role of medication. VC was documented as stating that he understood that he needed to take his medication to stay well and said that he would not stop taking it in the future without consulting his GP.

At a ward review on the 21 July 2020, attended by VC's mother, the consultant explained the importance of VC taking his medication and the plan for follow up. VC's mother enquired about the possible use of a depot, but it was agreed at that point that oral medication was appropriate for now. VC's family told the independent investigation that they were not told that a diagnosis of schizophrenia had been made.

On 27 July 2020, it is documented that VC discussed his discharge from hospital with a member of nursing staff. The notes state that VC spoke about being happy to leave and feeling ready. He said that he was more aware of his mental health and that he knew that he may need help before things became bad enough for him to come into

hospital. VC's family told the independent investigation that, at that time, they were of the opinion that VC was saying what he thought staff wanted to hear to enable him to be discharged from hospital.

On 28 July 2020, a ward review was attended by VC's mother, EIP Care Coordinator 1 and a member of the Crisis team to discuss the plan for VC's discharge from hospital. By this point VC was on Aripiprazole 10 mgs a day and it was noted that he was calmer and not presenting any management problems. It was felt that, following discharge, VC would benefit from short term follow up from the Crisis team following discharge with ongoing input from the EIP team.

On 30 July 2020, an update was given to the University, through its Mental Health Advisory Service[12] (MHAS) and the University was informed that VC was to be discharged the next day. It is documented in VC's clinical records that the University voiced concerns regarding VC returning to his accommodation.

On 30 July 2020 VC was reviewed by a Clinical Psychologist for the first time. The notes state that they talked about recognising signs of VC's mental health and deterioration. VC said that he would be able to do this by recognising that he is paranoid and that; feeling a 'lack of control', feeling as though people might be following him, and feeling very irritable may all be warning signs of him struggling with his mental health. VC said that if anything did arise, he would contact the Crisis team, his family, or his G.P. The notes state that no recommendation for further Clinical Psychology input has been made at this point.

On 31 July 2020, VC was discharged from hospital with a primary diagnosis of paranoid schizophrenia. The notes state that VC had stopped taking his medication two weeks after his previous discharge from hospital and within two weeks he was

[12] The MHAS is an advice and support service, designed specifically for a higher education setting and available to assist students who experience significant mental health difficulties to maximise their experience at the University

hearing voices. VC had reported that he was concerned that medication was impacting his ability to study for exams. The notes document that VC was experiencing derogatory third person hallucinations. The notes suggest that VC was discharged with greater insight into his illness and the importance of medication. The plan was for VC to be followed up by the Crisis team.

VC's family told the investigation that VC was discharged while his parents were on their way to Nottingham but before they had reached the hospital – instead VC was sent home in a taxi paid for by the hospital. There was nothing documented in VC's clinical records regarding arrangements made with VC's family for discharge.

5.1.6 Second episode of community care 31 July 2020 – 3 September 2021

On 1 August 2020 VC was seen in his home by a Crisis team worker. He told them that he could not find his medication, but he later phoned the team to confirm that he had found it.

VC was seen by a Crisis team worker on 3, 4 and 5 August 2020. It was explained that the purpose of the visits was to support VC with medication, but on the first two days he said he had already taken his medication before they had arrived and expressed some resentment at being watched to take medication. On 5 August 2020, VC took his medication with water in front of the Crisis team worker. There was no overt evidence of him appearing psychotic although some very slight delays in responses to questions were noted.

On 6 August 2020, VC was reporting to be free of psychotic symptoms and was engaging with the Crisis team and was not presenting as at risk of needing a hospital admission and therefore no longer met the criteria for the Crisis team. However, it was noted in the past that VC had deteriorated rapidly after discharge so it was agreed that he would remain with the Crisis team for another week.

A joint visit took place between the Crisis team and EIP on 6 August 2020. VC was seen again by the Crisis team on 8 August 2020 and his care was then handed over

to EIP on 13 August 2020. He was seen by EIP on 14 and 15 August 2020 and then weekly until 15 September 2020, with a phone call on 25 September 2020 and a home visit on 1 October 2020. The next appointment was scheduled for two weeks' time.

On 9 October 2020 VCs mother contacted EIP expressing concern that she had not been able to contact VC. EIP staff went to VC's home address the same day. A housemate said he was in the city centre and that they had no concerns about him. The following week EIP made several attempts to call VC and had further contact with his mother. VC was visited by a Nurse from EIP on the 26 October, it was documented that he did not really engage with the staff member but agreed to phone his parents.

On 5 November 2020 VC rang the ward consultant. The ward consultant explained to VC that he was not able to comment on his care, as he was not currently involved but encouraged VC to contact his community team. The ward consultant documented that VC seemed a bit cagey and unsure about making this contact. The ward consultant then shared details of this conversation with the EIP team.

An EIP home visit was subsequently arranged for the following day. During the visit no concerns were identified. VC was described as stating he was fine and that he did not need any help. A month's supply of medication was provided that day and it was noted that they were overdue, but that VC said he still had some medication remaining. The possible lack of concordance with medication was flagged by the nurse who visited VC on 9 November 2020 leading to an outpatient appointment being planned for three days later. However, on 10 November 2020 VC phoned asking for his appointment with EIP to be brought forward as he had something 'important to discuss'. A home visit was arranged for the same day, and it was documented that VC appeared to be psychotic. His medication dose was increased (to 15 mgs Aripiprazole). VC was documented as settling over the following weeks. It is documented that auditory hallucinations were present but were not concerning VC. VC's risk assessment was not updated at this point.

VC was seen weekly for the rest of November 2020 and into December 2020. At a medical outpatient review on 7 December 2020, VC was described as making slow but steady progress and having gained significant insight with better functioning. He was described as compliant with medication. For the rest of December 2020 and into January 2021, VC was reviewed fortnightly, starting some work on early warning signs and relapse prevention with Care Coordinator 1 in the middle of January 2021.

During a medical review at the beginning of February 2021 VC said that his symptoms had improved but did not attribute them to psychosis. He described some memory difficulties, and it was shared with him that this may be part of the cognitive deficit associated with his psychotic illness. He was described as making a slow but steady recovery but given that he was hearing some residual voices, his Aripiprazole was increased to 20 mgs a day. In mid-March 2021 VC was seen again by the psychiatrist to participate in a formal memory test which was described as encouraging with no real concerns. It was again discussed that his difficulties with concentration and memory could be the cognitive deficit of a psychotic illness.

A home visit took place on 13 April 2021 at which VC was described as reporting slight improvement since the increase in his antipsychotic medication (Aripiprazole). He was also updated by Care Coordinator 1 that the landlord was trying to seek compensation for the damage he had caused to the property prior to his previous detention under the Mental Health Act. Care Coordinator 1 agreed to contact the Police on his behalf to try and reduce any potential distress this might cause.

A further home visit took place a month later on 13 May 2021 at which VC was described as relaxed and well-presented, reporting that his previous experience of voices was quieter and, in the background, but still present much of the day. Although VC described being unconvinced that his medication had improved his symptoms, he was adamant that he was still taking it. The EIP worker documented that VC was less distracted and blunted (emotionally inexpressive) than on previous meetings.

From 29 May 2021, VC started calling his family more erratically and sounding more unwell, which, they recalled, was similar to leading up to his first admission. VC's mother therefore phoned the Crisis team as they were worried that VC was not taking his medication. The Crisis team subsequently carried out an over-the-phone assessment during which VC reported that 'he feels fine and relaxed...He reports not hearing voices, no worrying thoughts, he says he not noticed anything unusual or any visual hallucinations'. VC also said that he was taking his medication at 10am every morning. The Crisis team subsequently documented 'Clinically, I did not see a role for CRHT at this time, due to No obvious signs of deterioration and also I have not nursed [VC] before to note if he is masking his symptoms.' It was agreed that the Crisis team would liaise with EIP to share information regarding this contact.

The EIP team then visited VC at his home on 2 June 2021, it was documented that there were no concerns. There was not felt to be a change in VC's presentation, he was reporting ongoing faint voices which had not changed. He was adamant that he was taking his medication. On 18 June 2021, a further home visit took place with EIP at which VC was described as relaxed and well presented with no overt evidence of psychosis observed other than describing residual voices. A CPA review was arranged for 28 June 2021 which VC did not attend but was held over the telephone.

EIP visited VC at home on 8 July 2021, he reported feeling 100% back to his usual self, denying any concerns about his mental health. However, he did report "*barely noticeable"* voices and stated he was taking his medication as prescribed. VC was given a further 28 days' supply of medication.

On 30 July 2021, VC was offered a conditional caution by the police for the incident in May 2020 but declined the caution despite the risk of prosecution. The notes state that he 'refused to accept a conditional caution he wanted his day in court so he could contest it'.

VC was visited at home by the EIP team on 6 August 2021 and was documented as being irritable and short with the nurse who was delivering his medication. He failed

to attend his outpatient appointment on 9 August 2021 and was then contacted by phone and was described as being abrupt and slightly avoidant. He was visited the next day by the EIP team, and it was documented that there were no concerns. The doctor who attended the home visit along with Care Coordinator 1 described a stable mental state with no evidence of thought disorder and only the report of faint voices. VC was stating that he did not believe he had mental health problems but that he was happy to follow medical advice and take medication.

On 16 August 2021 VC turned up unexpectedly at the inpatient ward asking to speak with his inpatient consultant. He was seen by another member of staff who was asked by VC if they could hear voices whilst on the ward and whether they could communicate with artificial intelligence. The ward staff contacted the EIP team and they telephoned VC the same day to arrange to meet face to face three days later.

The EIP team visited VC at his home on 19 August 2021. It was documented that he was guarded and unkempt and that he was likely relapsing. No risks were noted that day, but it was documented that he was difficult to assess due to his guarded presentation. A plan was put in place to liaise with Care Coordinator 1 when they returned from leave and to arrange a visit for the following week.

On 24 August 2021 EIP staff attended VC's home after texting him an appointment but he did not appear to be in. When they rang him, he said he was not in, nor was he free to talk and asked for another appointment to be texted. He said he was fine and there was nothing to worry about.

On 31 August 2021 Care Coordinator 1 and a colleague visited him at his home due to concerns that he may be relapsing and to deliver a further supply of medication. It was documented that VC said he was no longer taking his medication and that he had no intention of continuing with treatment. He said he was not taking his medication because he was not psychotic and never had been and that he had no intention of seeing the EIP team any longer.

The notes document that VC presented with complex delusional beliefs. ‘Believing that the community mental health staff are working in collaboration with the judicial system and the hospital to create technology to cause his voice experiences/monitor him’. He was documented as lacking insight and was demonstrating mistrust.

The impression documented was that VC is currently relapsing (third relapse), he appeared paranoid/suspicious and was not trusting of services. The notes record that VC had ‘no insight’ and there was a risk of further decline in mental state.

In terms of risk, the records state that VC is: ‘usually a very personable, kind, polite and gentle man however when unwell he did break down a neighbours next door because he believed he could hear voices of someone in trouble next door. Lack of insight, [VC] doesn't appear to recognise that he has ever been unwell, behaviour can be unpredictable when unwell. We did not feel it was safe to continue to push the assessment at this time as [VC] appeared increasingly frustrated and mistrusting of us. I was also concerned that it was potentially quite difficult to get out of the flat due to a long corridor / hallway to the exit should we have needed to leave promptly. [VC] agreed it would be a good idea if we left it there, he then showed us out of the flat and abruptly closed the door behind us.’

Following team discussions, VC was referred for an MHA assessment and was placed on the bed waiting list. It was documented that VC was not to be sent to an out of area bed as VC and his family had declined this. Care Coordinator 1 also updated VC’s risk assessment at this point. Under risk formulation, it states that VC has ‘Nil insight, does not believe he has ever been unwell’.
On 2 September 2021 MHA assessment was attempted but VC was not at home.

5.1.7 Third inpatient episode 3 September 2021 – 22 October 2021

The next day (3 September 2021), a Section 135 warrant was obtained from a Magistrate, and was executed at VC’s flat. During the MHA assessment VC significantly assaulted police officers who were there in support. VC required tasering followed by pepper spray being used to restrain him. He was removed from his flat

and taken to the 136 suite and then detained under Section 2 of the MHA. VC refused medication over the following days and was nursed in seclusion due to his risk of violence and unpredictable behaviour (3 – 9 September 2021) while awaiting a Psychiatric Intensive Care Unit (PICU) bed. On 6 September 2021 VC was refusing oral medication but there were delays in administering intramuscular medication due to a lack of staff. When it was given, it was done so under restraint. Further injections were given under restraint on 7 and 8 September 2021.

On 11 September 2021, VC was admitted to a PICU at an independent provider. Whilst it was previously noted that VC should not be sent out of area, there was no PICU bed available within the Trust, so an out of area bed in a PICU was 'spot-purchased' at the independent provider in order to meet VC's needs at that time. On the same day, a risk assessment was completed. His risk of harm to others was documented as 'medium' and in the comments it is documented:

> 'High risk of violence and aggression, nursed in seclusion for the last week, He required CS gas and repeated firing of Tazers to subdue him sufficiently to be removed to the Cassidy Suite, and mechanical wrist and ankle restraints to transport him even after being CS gassed and tazered. Due to extreme levels of violence and aggression, physically assaulting a police officer by punching him on the face and attempting to assault other, an emergency shout for support went out from Officers on scene executing the S135 warrant, dictating that they were being assaulted and needed extra support.'

During this admission at the PICU, VC was treated with an antipsychotic drug, Haloperidol and was documented as having taken medication from the time of his admission. VC was documented as not presenting with any aggression or violence during his admission to the PICU. A further risk assessment was recorded on 14 September 2021 but there were no changes or additions from the one completed on 11 September 2021 as the risk was felt not to have altered.

Care Coordinator 1 attended a virtual ward round on 21 September 2021 and gave her opinion that VC had not recovered to his level of pre-illness functioning. VC was described as “superficial in contact, blunted in affect, hearing voices but describing that they were not bothering him". It was noted that his compliance with treatment was questionable, and a depot had been considered. During this admission it was documented that VC gave a detailed description of the delusional beliefs that he was holding at that time about being electronically harassed which he believed was because of him breaking a few lockdown rules.

A risk assessment completed on 21 September 2021 concluded that the risk had not altered from the previous two but adds that VC had not shown any aggression or violence towards others since admission, that he had been concordant with his medications since admission and that he had not tried to leave without permission.

On 23 September 2021, Care Coordinator 1 telephoned VC’s mother to provide an update. VC’s mother reported that she did not feel she had a full understanding of VC's current difficulties due to having no contact with the ward. It is documented that VC’s mother reported that she had tried numerous times to contact the team, however they never returned her calls.

On 24 September 2021, VC’s section was converted to a Section 3 of the MHA. Whilst he was assessed to be concordant with his medication, he was described as still lacking insight and it was noted that his delusional beliefs of persecution and conspiracy remained. On 1 October 2021, VC was stepped down from a PICU to an acute adult inpatient bed back in the area but with another independent provider. VC was still detained under Section 3 MHA 1983 at the time of his transfer. VC was documented to be settled but requiring ongoing care in an acute ward.

VC was described as settling well in the new hospital and engaging in some activities. His diagnosis was discussed with him (paranoid schizophrenia) but he minimised the severity of his mental illness and by that point was stating that his voices had disappeared completely. He also did not believe his mental state had relapsed and

described the Police getting involved because he had been stressed and then overreacted. He did admit to prior symptoms but said that they had previously gone away with Aripiprazole. His medication was changed to Aripiprazole and by the time of his discharge (22 October 2021) he was being prescribed 20 mgs a day. He was advised that he would need to continue medication long term. By the time of his discharge no psychotic features were noted and it was felt that there were no risks to himself, or others at that time.

On the day of VC's discharge, the independent provider completed a risk assessment. VC's current risk of violence was recorded to be low with a historic high risk noted. VC was also recorded to be low risk of non-concordance with medication with a historical medium risk in this area.

VC's family told the independent investigation that when VC was admitted this time, VC's mother was told that this would be a long-term admission, nearer to the full 6 months limit under a Section 3. However, VC was discharged after 25 days. There is nothing documented in the clinical notes documenting this discussion.

5.1.8 Third episode of community care 22 October 2021 – 28 January 2022

On 22 October 2021 VC was discharged home from the independent provider. The Trust notes suggest that EIP Care Coordinator 1 was not informed. The records suggest that EIP contacted the independent provider to ascertain what had occurred during the previous day's ward round. The Care Co-ordinator was informed that VC had been discharged on that day. However, the notes from the independent hospital provider described that EIP Care Coordinator 1 was informed about his discharge.

VC's family also reported that they were not made aware of VC having been discharged. VC provided a new address on discharge and whilst Care Coordinator 1 was on leave, a 72 hour follow up took place by phone on 25 October 2021.

VC attended an outpatient appointment with Care Coordinator 1 on 5 November 2021. It was documented that no concerns were identified but he was largely 'monosyllabic',

but stated he was taking his medication, although 10 mgs rather than 20 mgs which he said was an oversight. VC then failed to collect his next supply of medication.

VC attended his scheduled outpatient appointment on 19 November 2021. He was documented as being guarded and uncooperative. He was provided with 28 days' worth of medication (Aripiprazole 20 mgs). It was felt that VC was reluctant to engage with mental health services and doing "*the minimum required".* He then failed to attend any further appointments and attempts to contact him were unsuccessful in November and the first half of December 2021.

On 16 December 2021 VC contacted the EIP team and was documented as being angry and confrontational. He told Care Coordinator 1 that they should not have any contact with his mother as it was stressing her out and totally unnecessary. Plans were put in place to discuss his care with the rest of the team as well as to contact his mother to inform her of his decision. The next day VC collected his medication and was documented as being curt with the receptionist and having a hostile edge to him. VC then missed his next four appointments and failed to answer the phone on 31 December 2021 and 6 January 2022.

VC failed to attend an outpatient appointment on 17 January 2022. This was documented as being his 5th missed appointment. The EIP consultant psychiatrist documented:

> 'we will discuss the plan at MDT on Thursday. Consideration will need to be given to discharge as [VC] has essentially disengaged and we have not been able to monitor him. Perhaps a conversation with his mum and course tutors to see if there are any concerns currently will be prudent before considering discharge'.

Care Coordinator 1 received an email the following day from the University with details of an incident involving another student the previous day. The student who was VC's flat mate stated that VC had assaulted him and trapped him and their other flat mate in the flat requiring the Police to be called. The reporting student stated that the Police

had told him that although VC had intent to hurt him, because he (the reporting student) had stopped VC by grabbing and holding him and he (the reporting student) had not sustained any injuries, they could not arrest VC. The University expressed concerns about VC's presentation and him remaining in the accommodation. Through communication with the University, Care Coordinator 1 identified that VC had not informed the EIP team that he had moved house and the address that the EIP team held for VC was incorrect.

The trust told us that, also on 18 January 2022, they contacted the police regarding the incident, and were told that the police were unable to share further information.

On the same day, the approved mental health professional (AMHP), who was a registered mental health nurse, sought a warrant under Section 135 of the Mental Health Act because of VC's apparent deteriorating mental health and consideration that VC required a place of safety assessment. He was considered on discussion with the gatekeepers for admission (registered mental health nurses) to be presenting with psychosis and having disengaged from the EIP service. Flatmates described issues for about a month with screams being heard from his room and on one occasion VC had entered another flatmate's bedroom asking if they could hear screaming.
He was also reported to have assaulted one of his flatmates the previous night, in shared student accommodation. He reportedly locked his flatmates in the flat and refused to let them out.

5.1.9 Assessment under MHA but not detained

On 19 January 2022, VC underwent a Mental Health Act (MHA) assessment in the 136 Suite. He was not detained as he agreed to Crisis team intervention with daily visits to supervise medication concordance. VC refused to change his medication when it was suggested that it might be necessary to look at an alternative antipsychotic, saying that he had experienced side effects on other medications. It was documented that there were 'no imminent risks to self or others but there is a past [history] of aggression when unwell and in recent days his flat mate was worried about him'. It was documented that if it became clear that he was not engaging with support

from the Crisis team and further risks became apparent, admission should be considered. VC's clinical notes suggest that the University expressed a number of concerns over the subsequent days, noting amongst other things, that VC's accommodation provider did not want VC to remain in his accommodation and there were concerns that he was unwell and not meaningfully engaging with support services.

On 21 January 2022 VC was seen by the Crisis team. It was documented that he took his medication but then appeared to put his hand to his mouth and throw something in the bin which was most possibly his medication. VC was then seen daily until 25 January 2022 when he mostly appeared to be taking his medication although he was reluctant to drink water after putting the medication in his mouth. On 27 January 2022 a further MHA assessment was planned after discussion with the community consultant as there were ongoing concerns about medication concordance, and not engaging with the monitoring of his mental state by CRHT.

5.1.10 Fourth hospital admission 28 January 2022 – 24 February 2022

On 28 January 2022 a further section 135 warrant was obtained to gain access to VC at his home and VC was detained under Section 2 of the MHA. On the same day VC's core assessment was updated and it was documented that VC did not engage in the assessment. Depot medication was discussed but VC refused this as a route of medication stating he was taking his medication. He also refused voluntary admission to hospital. The notes suggest that Section 3 under the MHA had been considered but it was felt that a further assessment was required due to a lack of clear psychopathology at that time. The next day, VC was transferred to an inpatient ward under Section 2 of MHA. It was documented that liaison took place with the University and VC's mother who reported that he had been calling his parents daily and did not seem unwell to them.

VC was granted Section 17 leave[13], to have short periods of unescorted leave. On 3 and 4 February 2022, it is documented that the University contacted the ward to report that VC had returned to his accommodation. The University raised concerns regarding risks to those in the accommodation. When ward staff raised this with VC he denied attending his previous address and said that he had remained in the local area whilst taking leave. It is documented that he was guarded about what he actually did or how long he took. It was explained to VC that his leave would have to be restricted if he had attended his previous address. The staff member then checked the Section 17 leave record. The time VC left the ward was documented as 14:07 and it is recorded that he had intended to leave for 1hr. No time of actual return is documented. This was subsequently raised as an incident. The plan in the notes was documented as: 'Given coincidence of time of allegation with time of leave being granted, it is likely [VC} did not adhere to leave requirements, although it is difficult to be certain given documentation S17 leave restricted as a result, to be reviewed at MDT on Monday'.

The University gave the ward a number for one of VC's flatmates who could provide more context to the incident which involved the police. The ward spoke on the phone to the student who reported having concerns for VC's mental state for the past month. They described screaming from his room and having disputes about hygiene.

Over subsequent days on the ward VC was described as calm and settled maintaining a low profile but apparently taking his medication with no concerns. By 7 February 2022 VC was granted escorted leave from the ward (30 minutes at a time), on a one to one with a member of the nursing staff. On 8 February 2022, VC said that he did not agree with the admission and did not believe that he had a mental health issue. He reported that he was going to engage as minimally as he could, keeping out of people's way, until he could be discharged and continue with his education.

[13] Section 17 leave is when a person who is detained under the Mental Health Act can leave hospital for a short period of time, usually with a carer or a nurse. It's a way of testing whether they can cope outside hospital and whether they need to be detained any longer.

At a ward round on 10 February 2022, attended by his care coordinator, the issue of depot medication due to non-compliance with oral medication and the role of a Community Treatment Order (CTO) was discussed. However, a CTO would only have been possible if VC had been on a Section 3. VC denied being non-compliant with medication prior to admission and was again clear that he did not want to have depot medication. His reasons were accepted, and he was not prescribed depot medication, although it was documented that there seemed to be an element of paranoid thinking regarding discussions with other professionals.

It was explained to VC that the University mental health advisory service (MHAS) was aware of what has been going on and that he was in hospital. VC said that he would rather they did not have contact with the MHAS. VC reported that he did not think it was appropriate for the hospital to get involved with other areas of his life.
It was documented that depot should be considered if he relapsed again.

On 14 February 2022 VC's final care plan was completed and he was granted unescorted leave. At a ward round on 17 February 2022, it was again reiterated to VC that the community team thought a depot would be beneficial – the notes state 'concerns about his level of engagement and concordance with prescribed medication by his community team. This is the 4th admission in the past 2 years and thoughts of community team are, he would be better placed on a depot and CTO as risk to others increase when [VC] is unwell. [VC] is against this and wants to continue with oral medication'.

VC was described as happy to engage with the community team and a provisional discharge date was set. VC was described as appearing guarded about telling staff where his new accommodation would be.

On 24 February 2022 VC was discharged from hospital in the presence of his EIP Care Coordinator 1. At the time of the discharge VC was no longer under section of the MHA which meant, as with previous discharges, that he would be engaging with mental health services on a voluntary basis. His medication was to continue as

Aripiprazole 20mgs once a day. VC continued to refuse moving to depot medication reporting that he was happy to take his medication orally. He was documented as being guarded but no psychotic symptoms were present. The documented plan was for Care Coordinator 1 to follow him up at his new, non-student accommodation.

5.1.11 Fourth episode of community care 24 February 2022 – 23 September 2022

VC received his 72-hour follow-up by Care Coordinator 1 on 25 February 2022 when he was described as remaining quite abrupt in responses, which was felt to be more of a reluctance to share information with services rather than psychotically driven. VC attended the EIP team base on 11 March 2022 to collect medication but stated that he did not have time to talk.

On 28 February 2022 a risk assessment was completed. His risks were documented as:

> 'given history of violence and aggression, community appointments to take place at Stonebridge Centre. Should home visits be required, no lone working, joint visits recommended. Risk to others: appears to experience persecutory delusional beliefs that thoughts can be influenced and controlled by computer systems specifically developed to interfere with the mind. History of violence and aggression when detained…, violence and aggression towards housemates… poor insight, does not agree that he has been unwell over the last 12 months. Poor engagement with community services, history of non-concordance with medication.'

When VC attended his planned medical review with the community consultant psychiatrist as an out-patient on 14 March 2022 he was described as well presented, articulate and engaged. He denied missing any medication leading to his admission. He described feeling mentally well and stable and denied any current psychotic symptoms. It was agreed that VC could collect his medication on a fortnightly basis, and it appeared that it was his wish to keep his contact with the team as low key as

possible. No changes were made to VC's medication or management plan and it was documented that VC would be reviewed again in three months.

VC attended a further appointment on 1 April 2022 to collect 14 days' supply of medication, but no discussion took place with his care team. He was not able to enter the building due to a COVID-19 outbreak. The notes record that he was next scheduled to collect medication on 15 April 2022. On 7 April 2022 Care Coordinator 1 called VC and asked for him to collect his medication a day earlier due to a bank holiday but VC did not answer the call. The arrangements were however confirmed four days later.

On 19 April 2022 VC texted Care Coordinator 1 to ask if they were still on leave as VC wanted a home visit to 'get some information'. After discussion with the team leader, this request was refused given the historical risks of violence, aggression and hostage taking. Home visits were considered not to be appropriate unless absolutely necessary. It was decided amongst the team that it would be best to continue with the plan to offer appointments at the EIP office. Care Coordinator 1 messaged VC to inform him that he would be offered appointments at the EIP office and that he could attend an appointment on either Thursday or Friday. VC replied to say that he may attend next week when he is able to get to the centre. He collected his medication the following day and a further appointment with Care Coordinator 1 was scheduled for 28 April 2022.

On 26 April 2022, the University emailed Care Coordinator 1 to share concerns that VC had attended his previous accommodation and was asked to leave by security. VC reported that he had asked his former flatmate if he had any mail at the address. The University records suggest that there was further contact between the University and the EIP service on 29 April 2022.

5.1.12 Transfer of VC to a new care coordinator within the EIP service

On 28 April 2022 the EIP team made the decision, as part of a multi-disciplinary team (MDT), to transfer VC to a new care coordinator. The notes state: 'following a risk assessment and discussion in MDT, agreed it would be appropriate to transfer [VC] to

a new care coordinator, preferably 2 CPN's'. The suggestion was that VC should be seen by two community psychiatric nurses at any interaction.

The following day VC attended an outpatient appointment with Care Coordinator 1. He was documented as being guarded and hard to engage with but that there was no overt evidence of psychosis. Care Coordinator 1 documented that VC had confirmed that he had finished university but had no current plans. She documented that 'he was spending time 'preparing', when asked what for he said 'whatever is next.'

He was noted as not wanting to discuss his text message where he had asked if he could meet to '*get some information'*. No other concerns were documented. It was documented that his next appointment would be with his new care coordinator (Care Coordinator 2) and medication was due for collection on 13 May 2022.

VC attended fortnightly to collect his medication between 13 May 2022 and 15 June 2022. When he collected his medication, it was documented that VC left without talking or had only brief interaction with Care Coordinator 2.

On 13 June 2022, VC failed to attend his three-monthly medical review with the EIP consultant psychiatrist. A care programme approach (CPA) meeting was subsequently scheduled by Care Coordinator 2 for 1 August 2022.

On 24 June 2022, Care Coordinator 2 phoned him to arrange for medication collection but VC stated that he had enough until 1 July 2022. Care Coordinator 2 documented that he will offer to take VC's medication to him if he can find another colleague to accompany him.

VC attended to collect his medication on 4 July 2022, but Care Coordinator 2 was out. VC left once he had his medication. It was recorded that his next medication needed to be collected on 18 July 2022.

On 18 July 2022, Care Coordinator 2 was on leave so another EIP worker contacted VC, and the following text conversation was documented in the notes.

EIP: Hi [VC] it's [name] from [EIP] are you coming to collect your meds today? what time are you thinking?

VC: Not in the UK at the moment

EIP: Are you on holiday? Hope you're having a nice time. When do you think you'll be back to get your medication?

VC: I'm good. I'll probably be back in [location] in October

EIP: What about medication?

VC: Still have some. Won't make much difference.

EIP: You'll run out by October. Do you not find the medication helpful?

On 25 July 2022, Care Coordinator 2 called VC's mother. She reported that she was unaware VC had gone abroad. Care Coordinator 2 then tried to phone VC, but he did not answer, he subsequently left him a voicemail asking him to call.

On 27 July 2022, Care Coordinator 2 tried to phone VC again as he had failed to collect medication. Care Coordinator 2 then contacted VC's mother who said that VC was in Nottingham and was not abroad. Care Coordinator 2 scheduled a home visit with another colleague to take medication to VC on 1 August 2022.

On 29 July 2022 Care Coordinator 2 attempted to contact VC again but was unsuccessful.

It is not clear from the notes whether Care Coordinator 2 and his colleague attempted to visit VC at his home address on 1 August 2022. However, VC failed to attend his rescheduled CPA meeting with the medical team that day.

Care Coordinator 2 attempted to phone VC again on 3 August 2022, but he did not answer. It was documented that VC's phone appeared to be turned off and Care Coordinator 2 was unable to leave a voicemail. The plan was recorded that Care Coordinator 2, and a colleague would visit VC's address the next day to try to establish contact with him. Later that day, Care Coordinator 2 spoke with VC's mother who reported that VC had been in contact with his sister. Care Coordinator 2 explained that he and a colleague would attempt to visit VC the following day.

On 4 August 2022, Care Coordinator 2 carried out a home visit with a colleague, but the address appeared to be incorrect. The person who answered the door said that nobody of that name lived there. Care Coordinator 2 documented that VC had a history of giving false addresses and that he would discuss the plan with the team manager and consultant psychiatrist on Monday. He documented that potential options would be to discharge VC to the GP or report him as a missing person.

It is documented in VC's care records that on 9 August 2022 he requested access to his records. VC gave a different address to the one he provided to the EIP on discharge from his last inpatient stay.

On 17 August 2022 Care Coordinator 2 wrote to VC to try to arrange a meeting. In the letter Care Coordinator 2 comments that it 'seems like a long time since we last met' and asks whether there is something that he can do to help VC. The letter asks VC 'Do you still want to engage with our services at this time? Perhaps you could give me a ring…and we could have a chat.' Care Coordinator 2 also states that they have a

supply of VC's medication 'if you want them'. He finishes the letter by saying 'can we have a chat and work something out together.'

VC was discussed at the MDT meeting the next day. The records document that in the meeting VC's request for access to his documentation and notes was discussed. It was confirmed that VC had not been in touch despite the letter asking him to contact his care coordinator. It was noted that he had not been supplied with medication for several weeks. Care Coordinator 2 stated that they would contact VC's mother for any help or assistance.

Care Coordinator 2 spoke with VC's mother on 31 August 2022. She reported that she had not seen VC face to face for many months, but she had a telephone conversation with him in the last week. VC's mother said that she had attempted to visit VC, but he was not at the address she was familiar with. Care Coordinator 2 gave VC's mother the most recent address he had for VC. VC's mother reported that she would attempt to contact him. Care Coordinator 2 documented that:

> 'I feel in the circumstances I will arrange a visit with a colleague to go out and see [VC] to determine his mental state and general wellbeing.'

This visit did not take place and the next entry in the clinical records is on 23 September 2022 where it is recorded:

> 'Discussion within MDT on 22.09.22, as no contact has been made with [VC] for a period of time despite attempts to make contact and having done cold calls, decision made within the team to discharge back to GP due to non-engagement with view for GP to refer back to services in the future if needed.'

A letter to VC's GP was written the same day, simply outlining non-contact and that VC had been discharged.

There was no contact between VC and mental health services or his GP between this date and the attacks in June 2023.

6 Analysis of the Trust's serious incident investigation report

The independent investigation was asked to review the Trust's internal serious incident investigation report and assess the adequacy of its findings and recommendations. Then, if appropriate, to build on the findings of the internal investigation to avoid duplication.

The Trust has a policy entitled 'Managing Serious Incidents (SI) and Reporting and Learning from Deaths'. The version that was in place at the time of this incident was last ratified in July 2019 and was due for review in August 2024. The policy states that its purpose is to:

> "…provide a consistent interpretation of the 2015 NHS England Serious Incident Framework (SIF), ensuring the management of Serious Incidents (SIs) is clearly defined, embedded and understood across the organisation."

It goes on to say that the policy:

> "outlines the processes and procedures to ensure that SIs are identified correctly, investigated appropriately and, most importantly, learned from to prevent the likelihood of similar incidents happening again… This policy sets out the reporting arrangements, actions to be taken, and by whom, in the event of SIs. It will ensure that there is a consistent approach to the management of SIs and that staff at all levels are aware of their roles and responsibilities in the reporting and management of such events."

The Patient Safety Incident Response Framework (PSIRF) was introduced in September 2022 and was to be implemented by all Trusts within the following 12 months. PSIRF aims to contribute to a move towards a safety management system

across the NHS and develop an effective patient safety incident response system. The four key aims of PSIRF are:

1. Compassionate engagement and involvement of those affected by patient safety incidents.
2. Application of a range of system-based approached to learning from patient safety incidents.
3. Considered and proportionate responses to patient safety incidents.
4. Supportive oversight focused on strengthening response system functioning and improvement.

The Trust told the independent investigation that it commenced transition to PSIRF in April 2024.

Comment

Wider conversations suggest that whilst the NHS England website states that organisations are expected to transition to PSIRF by Autumn 2023, it is not uncommon for Trusts, in particular mental health Trusts to still base their serious incident policy on the Serious Incident Framework.

The SI author told the independent investigation that they followed a systems-based approach to the review, consistent with PSIRF requirements. However, the SI predominantly reads as a comparison of events to policies and procedures in place at the Trust without obvious consideration of the system factors impacting on any deviation from policy, for example the impact of resources and staffing.

Comment

A true systems approach includes consideration of the breadth of the system rather than focusing solely on the sharp end findings and actions of frontline staff. A systems approach seeks to understand how organisational structures, processes of assurance or organisation of services impacted how teams worked/co-ordinated and multi-agency engagement. However, the SI panel was limited in their approach because of access to evidence.

In line with the Trust's policy, an Initial Management Review (IMR) was undertaken within three working days. The IMR did not identify any immediate safeguarding concerns. The incident was reported on the Strategic Executive Information System (StEIS) and VC's clinical records were secured.

In line with the Trust's policy, a level 2 Comprehensive Investigation was commissioned which is documented as having to be completed within 60 working days. The Trust commissioned an independent Chair for the internal investigation panel; the Chair was recruited in July 2023 and the two other panel members were identified and in place in August 2023. However, However, the SI was prevented from commencing as VC had been charged with murder and the matter was sub-judice. The SI panel were given permission to undertake a tabletop review of VC's clinical records in October 2023 and were given subsequent permission by the Police to undertake staff interviews in November 2023. The final SI report was produced in February 2024.

For the above reasons, the SI investigation was delayed in starting and was unable to interview staff initially. However, this was out of the control of the Trust and the SI panel. The Trust and the ICB made efforts to work with the Police to enable the SI investigation to take place.

The SI panel undertook interviews with seven members of staff and reviewed a variety of documentation including VC's clinical records and Trust policies and procedures. The SI panel was not given access to the notes of the independent providers or interview staff in those settings. They were also unable to meet with VC or his family due to the on-going police investigation. The SI panel also did not have access to VCs GP records nor were they able to meet with staff within the primary care setting.

Findings of the SI investigation

The SI investigation identified areas of good practice in the care and treatment of VC and highlighted a number of areas where practice could have been improved.

The report details three areas which the SI panel considered to be particularly good practice in VC's care and treatment:

- On both occasions, the SI panel considered the communication and handover process between the Crisis resolution and home treatment team (CRHT) and the early intervention in psychosis team (EIP) to be "very good" and in line with best practice.
- The SI panel considered that both community and inpatient staff communicated "extremely well" with VC's family. The SI panel considered that there "was evidence that the family understood when VC was not well, and the teams were responsive when the family raised concerns".
- The SI panel stated that they were "impressed with the knowledge that each staff member" in the EIP held in relation to VC, even if they had not worked with him directly.

The SI report detailed ten learning points across the following seven areas:

1. The level of Trust oversight when placing people in out of area beds.
2. The need for greater clarity with arrangements between the Crisis team and EIP for out of hours intensive support.
3. The appropriate use of the Mental Health Act (MHA). On one occasion in VC's care a Section 2 was used rather than 3 - the SI panel considered that VC reached the criteria for a Section 3.
4. Greater consideration of depot medication and a community treatment order (CTO) to manage VC.
5. The need for the weekly team meeting to be clearly structured and documented to enable risk of service users to be clearly discussed and recorded.
6. The management of VC's discharge from mental health services back to his GP in September 2022.
7. Consideration of culture and ethnicity with clinical risk decision making.

Comment

The independent investigation understands that the Trust was unable to follow its Managing Serious Incidents (SI) policy in relation to contact with VC, his family, and the victims of the serious incidents due to the complexity of the Police engagement. Permission was granted by the Police for a duty of candour letter to be sent to all six victims via the police Family Liaison Officers, in November 2023. However, the SI panel was not allowed to make direct contact with VC or with his family. The SI investigation was therefore conducted without that valuable perspective. The independent investigation also understands that the SI panel did not have access to the notes of the independent providers where VC had two inpatient stays, nor were they able to communicate with the GP or the University.

The independent investigation considers the SI investigation report to be thorough, setting out events in a clear timeline. There is an inaccuracy in relation to VC's third inpatient admission whereby he was initially detained on a Section 2 but this was converted to a Section 3.

The ten learning points developed by the SI panel are evidence based and the investigation report sets out the evidence which leads to the finding in each area and the subsequent learning point. It is clear within the report what is fact versus the professional opinion of the SI panel. The SI investigation broadly takes a systems approach and considers factors outside of individuals, such as workload and staffing capacity which contributed to decision making.

The SI investigation was limited as the panel was not allowed access to all evidence that may have provided a different perspective on some of the findings. For example, in relation to the family's perspective of quality of engagement.

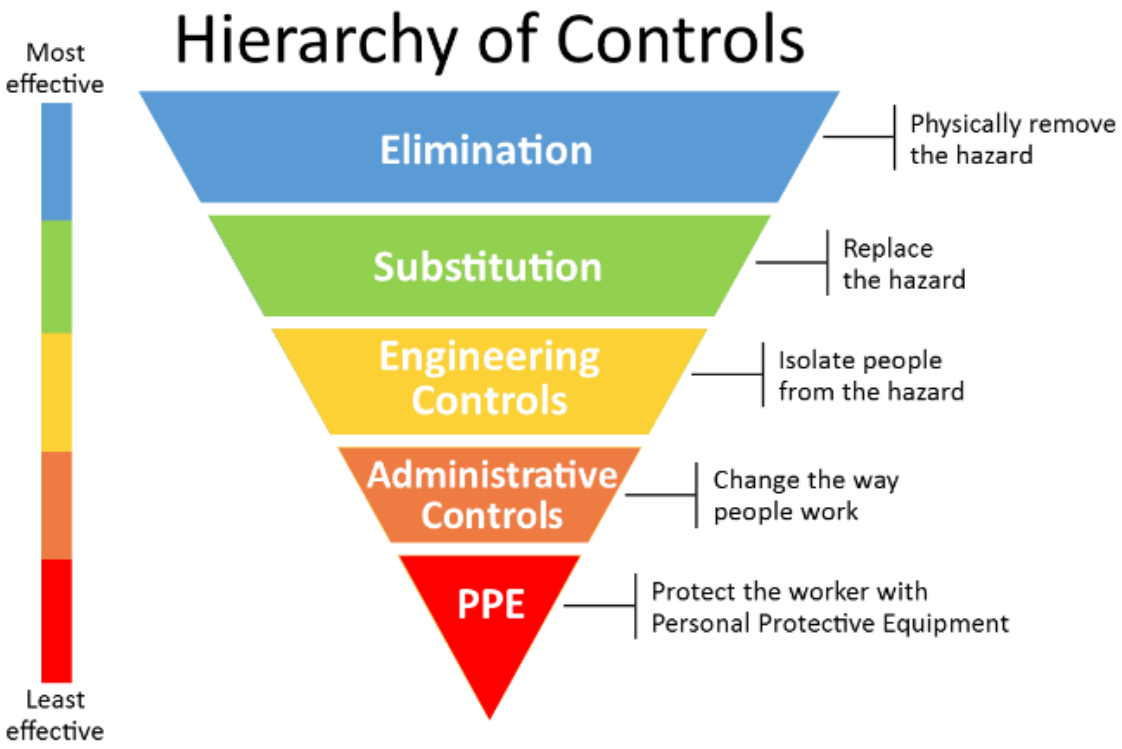
In relation to the areas of particularly good practice highlighted by the SI panel, the independent investigation appreciates how the panel reached their conclusions about the knowledge of the EIP team and the positive communication and handover between the Crisis team and EIP. However, given that the SI panel were unable to interview VC and his family it may have been prudent to have been more cautious when describing the nature of the positive communication between the Trust and the family.

Recommendations / implementation of action plan

The Trust fully accepted the SI investigation report, and an action plan was developed jointly between the Operational Services and the Patient Safety Team. It set out the goals, timeline and evidence required to support completion. The action plan was presented to the Executive Leadership Team in April 2024. An update on progress was subsequently presented to the Executive Leadership Team in July 2024.

The action plan sets out 18 actions to be taken to address the ten learning points. The proposed actions are varied but primarily consist of administrative controls such as changes to policy and process and training for staff. All actions have a plan for implementation and target dates for completion. The Trust has also introduced a programme of audit in some areas to assess the compliance with the recommended changes.

The diagram below demonstrates the hierarchy of controls that can be placed within a system. At the bottom are the least effective controls through to the most effective at the top. The majority of the recommendations made in SI report were made at the administrative controls level of the hierarchy. There are important controls that can be put in place at this level, however this is only one approach and stronger controls could be considered.



A Trust Board Executive told the independent investigation that there has been progress made against the action plan and subsequent evidence was provided to demonstrate that 90% of the actions have now been completed.

It was acknowledged that a lot of staff have been deeply impacted by the events in June 2023 and one of the primary focuses has been on supporting staff to be in a position to take the action needed to make the necessary improvements. An Executive described a recent learning event which was attended by 90 staff.

In relation to the assessment and management of risk, the Executive described a strengthening of risk assessment and management meetings (RAAM) and the development of a new training package around risk formulation and documentation.

Regarding discharge from mental health services, the Trust has now instigated a no discharge without face-to face contact and multidisciplinary team discussion, the Trust can now audit this data through the safe now metrics. The ‘safe now’

programme enables key quality metrics to be identified and flags whether practice in a given area (e.g. discharge) is being delivered in a safe and effective manner.

Comment

The independent investigation considers that it is good practice to not discharge an individual without face-to-face contact and multidisciplinary team discussion. However, we consider that such discharge should also involve a discussion with the GP and a review of risk.

The Executive also acknowledge work done to improve the oversight when a patient is placed in a bed out of area, although recognised there is still further work to do in this area.

7 Independent investigation review of care planning, delivery and oversight

7.1 Background

This independent investigation has identified the recognition and management of risk as a core theme of the investigation's findings. This includes how risk was recognised, understood, communicated and managed across all of the care settings that provided care and treatment for VC.

This section will consider the evidence and reflect how insight and management of risks relevant to VC influenced the decisions and outcomes associated with the delivery of care and treatment. The independent investigation will consider the understanding and management of risk across the whole system from the Integrated Care Board (ICB) and Trust Executive Board oversight through to the frontline delivery of care.

7.2 What is risk and risk management?

The basic components of a risk management process, irrespective of industry or setting, include several distinct stages (HSE, Risk assessment: Steps needed to manage risk - HSE:

- Understand the context (internal and external factors)
- Identification of hazards (a contributor to an adverse event)
- Assessment of risks (likelihood and consequence hazard will occur)
- Evaluate the risk (judge level of acceptability based on predefined criteria)
- Control the risk (actions taken to manage and reduce or mitigate the risk)
- Reviews or evaluation of effectiveness of controls.

There is a recognition that healthcare currently does not have a structured and comprehensive approach to managing safety risks as seen in other safety critical industries (HSSIB, 2023, Safety management systems (hssib.org.uk).

The HSSIB report highlights a lack of a transparency and accountability in healthcare's existing approach, which are both fundamental properties of any system intended to manage safety and are embedded within other safety critical industries. The implication of this is that accountability and responsibilities can become misaligned, clarity around escalation of risks may fail and gaps can form in oversight of safety across the context of services.

We have set this out in some detail because we realise that healthcare is not applying the same standard as other industries when it discusses risk assessment.

The last guidance published by the Department of Health (now the Department of Health and Social Care) into the management of clinical risk in mental health was produced in 2009. Assessing and managing risk in mental health services - GOV.UK (www.gov.uk)

The guidance describes the importance of risk management in developing flexible strategies to try to prevent negative events from occurring and where this is not possible, to minimise the harm caused. In mental health services the term 'risk' is used to refer to known outcomes associated with the care and treatment of people with mental health conditions these include risk of violence, self-harm/suicide or self-neglect.

The DH 2009 document defines risk as:

> 'The nature, severity, imminence, frequency/duration and likelihood of harm to self or others. A hazard that is to be identified, measured and ultimately, prevented.'

This is at odds with formalised risk management approaches used as described above. Despite the terminology of hazard being used within the definition, this term is not used anywhere else in the guidance to support clinicians to appropriately consider and manage specific hazards, which may be dependent upon different clinical settings e.g., inpatient vs community setting.

The approach described refers heavily to clinical judgment used to inform assessment of likelihood and consequence of potential adverse events. This is at odds with formalised risk management approaches as described above, which seeks to understand and manage identified hazards within different contexts, and to evaluate how intended controls impact known hazards to mitigate or reduce risks to an acceptable level.

The philosophy described by this document requires clinicians and organisations to achieve a balance between the care needs and management of risks through 'positive risk management'[14].

The Royal College of Psychiatrists also refer to 'positive risk management', suggesting the need to weigh benefits of interventions and patient autonomy (Royal College of Psychiatrists, 2016). The independent investigation notes this document was due for revision in 2021. The more recently published NHS England (2019), Framework for community mental health for adults also refers to:

> '…a shift away from risk assessments and ineffective predictive approaches to safety planning and positive risk taking, with staff supported by managers and to do so under progressive, partnership clinical governance arrangements.'

These documents all imply the need for collaboration of service users, carers, staff and organisations to be transparent and inclusive around decision making, acknowledging all decisions will hold an element of risk due to the nature of mental health illness. The DHSC (2019) document is aimed at mental health practitioners and refers frequently to clinical risk management, whilst acknowledging the organisation has an equal responsibility to the process of risk management.

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[14] Positive risk management requires consideration to 'weighing up the potential costs and benefits of choosing one action over another' whilst 'minmising the risks to the service user or others' (P11).

However, the details of what a ‘positive risk management system’ looks like is not described and left for clinicians and organisations to interpret relevant to their clinical contexts.

In September 2024 the Health Services Safety Investigation Body (HSSIB) published an interim report where they make four safety observations. Relevant to this investigation are the two observations which focus on the need for a person-centred approach to biopsychosocial assessments and safety planning. Also, the need for the involvement of patients and their families in conversations about an individual's wellbeing.

NHS England are undertaking a number of initiatives in relation to safety planning. Two of these are cited in the HSSIB interim report:

- ‘NHS England, working with the National Collaborating Centre for Mental Health, is identifying 10 organisations to lead work to co-produce personalised approaches to safety planning in inpatient services. The learning will be shared through national learning networks. This is expected to be complete by March 2026.
- NHS England is producing national guidance on Safety Assessment and Safety Planning, specifically relating to person-centred safety assessment and planning, to support organisations in complying with the National Institute for Health and Care Excellence guidance ‘Self-harm: assessment, management and preventing recurrence’. This is expected to be complete in April 2025.’

Creating conditions for learning from deaths and near misses in inpatient and community mental health services: Assessment of suicide risk and safety planning (hssib.org.uk)

The management of risk implies appropriate controls or safety measures are in place that are considered sufficient to reduce or mitigate known hazards. Such controls may either reduce the likelihood or severity of the consequence of an adverse event.

We found the approach to risk assessment adopted by the Trust did not fully consider all the potential hazards in the context of the different treatment settings in which staff were managing VC. It was outside of the ToR for this independent investigation to consider how other Trusts approach the assessment and management of risk, but the investigation was told by clinical experts that there is national variability in understanding the term risk in mental health.

That said, there are considerable human variables in mental health which impact on risk. In mental health care risk has moved from old language of dangerousness, then to predict and prevent and now to a greater recognition of the complexities, the importance of relationships including families / carers and dynamism of risk.

7.3 Care and treatment

This section will consider how the breadth of the system influenced the quality and approach to care and risk management of VC as an inpatient and when he was cared for in the community. In line with its ToRs this investigation focuses upon the risk of violence and harm to others rather than risk of suicide. However, it is important to acknowledge that VC's family told the independent investigation that their biggest concern when VC was unwell was that he would take his own life, not that he posed a risk to others.

The independent investigation considers the key elements of VC's care and treatment under the mental health services and national expectations around care delivery. The report presents recognised national and local guidance relevant to VC's care and will describe variability and explore the reasons for this, finally reflecting upon the adequacy of risk management throughout his care. The areas are divided into:

- Care planning and documentation of risk assessment
- Diagnosis and medication
- Capacity and use of Sections under the Mental Health Act
- Consideration of a Community Treatment Order

- Assertive outreach
- Out of area placements
- Discharge from services
- Oversight and assurance
- Involvement of the wider system

7.4 Care planning and documentation of risk assessment

7.4.1 Introduction

This section intends to reflect where certain risks were left unmanaged at one level of the Trust, requiring levels closer to the frontline to absorb and attempt to manage uncontrolled risks. This is a recognised outcome of organisations where risk management systems do not enable those higher in the organisation to understand the reality to delivering services within the appropriate standards or guidance. Frontline work may adapt to accommodate organisational constraints or create new norms of work as they attempt to work in such disconnected systems, which ask for adherence to guidelines without system or resources to enable this to happen.

Decisions made by an individual clinician will make sense to them in the context of this new norm, however, with hindsight and without this context, comparisons made against recognised best practice and guidance can appear misaligned.

7.4.2 National and local guidance

The Care Programme Approach (CPA) was introduced in 1990 to provide a framework for effective mental health care for people with severe mental health problems. Its four main elements were:

1. systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
2. the formation of a care plan which identifies the health and social care required from a variety of providers;
3. the appointment of a key worker (care coordinator) to keep in close touch with the service user, and to monitor and co-ordinate care; and
4. regular review and, where necessary, agreed changes to the care plan.

The CPA model was reviewed in 1999 with the publication of the Mental Health National Service Framework and to incorporate any lessons learned since its conception.

In March 2008, Refocusing the care programme approach: Policy and positive practice guidance was published, which updated the policy and set out guidance for Trusts and commissioners to review local practice to refocus CPA within mental health services.

The description of best practice (DHSC 2009) provides the basic ideas around risk management. These describe the need for risk management plans to include a summary of risks and actions to be taken in the response to crisis and the need to articulate the level of risk management and appropriate intervention.

In March 2022, the Community mental health framework replaced the Care Programme Approach (CPA) for community mental health services. The plan was to enable services to shift away from an inequitable, rigid and arbitrary CPA classification and increase the standard of care towards a minimum universal standard of high-quality care for everyone in need of community mental healthcare. Lived experience experts told us that they were included on the development of the new framework up until the point where the Care Programme Approach aspect was removed from future guidance. They raised concerns that removing this aspect of care delivery may result is a loss of oversight of some individuals with a severe mental health condition.

In March 2022 NHS England published a position statement which said:

> …The shift does not mean taking away any positive aspects of care that someone currently on the CPA is experiencing... Those currently on CPA should be gaining access to high quality care through the transformation of services and additional investment. Given the CQC's regular findings in its annual community mental health surveys that people on CPA report relatively better experiences of care than those not on the CPA, the new system of care envisaged in the Framework should be pulling up the standard for all."

At the time VC was in contact with mental health services the Trust had an adult mental health care programme approach (CPA) procedural policy in place. The

policy was implemented in October 2017 and was last ratified in August 2021. The policy states ‘the Care Programme Approach provides a framework for the delivery of personalised mental health care and ensures that those with mental illness/disorder do not fall through the safety net of care services.’

Comment

The Trust should have had a policy in place which reflected the new community mental health framework with a move away from CPA. The Trust ‘s new Personalised Care policy was ratified in June 2024.

The Trust CPA policy states that once the decision has been made to place someone on CPA Pathway, a care plan should be created using the core assessment documentation. As part of the care plan, a crisis and contingency plan should be completed as follows:

- highlighting early indicators of relapse
- who the service user is most responsive to
- how to contact this person
- previous strategies which have been helpful
- where to obtain help in a crisis
- what to do in the event of the service user disengaging from services
- What extra provision will be in place for the first three months after discharge due to increased risk of suicide (ref Safety First 2001)
- Any advanced decisions or statements (future wishes) identified

The Trust’s policy states that, at a minimum, the CPA documentation should be reviewed annually, and the assessment process should form the basis of the discussion.

Whilst CPA was still in place as a nationally recognised model of care delivery, in 2019 NHS England published ‘The community mental health framework for adults and older adults’ which sets out a collaborative model of care delivery across the healthcare system. However, there is no evidence that this model was reflected in

the governance and processes for delivering care and the communication and management of risk at the Trust during the period in which VC was under their care.

In relation to risk, the Trust's CPA policy states that 'risk to self and others should always be assessed in the context of a service user's capacity to make an informed choice about the risks they are taking.' It goes on to say 'risk assessment has always been part of good clinical practice but there is now greater emphasis on explicitly carrying out a risk assessment and documenting the outcomes. In undertaking risk assessment, the gathering of information from all sources and interaction with the service user is crucial, the completion of the paperwork evidences this process and provides a framework to support it.'

The Trust CPA policy says that when completing a risk assessment, it is important to consider who else may have information that will be relevant or can corroborate what information is already gathered. Other staff and agencies may have valuable information.

The policy lists a number of principles that professionals should ensure when assessing, care planning, and reviewing risk:

- Risks are identified, documented clearly and decisions clearly communicated.
- Relevant legislation which may impact on the outcome of the assessment is considered e.g. Mental Health Act 1983.
- Risks are re-assessed when circumstances change.
- Protective risk factors are identified and service users are supported to make informed choices including identification of ways of reducing risks.
- Outcomes of risk assessments are communicated and shared appropriately.
- Carer's views of risk are also sought and incorporated.

The CPA Policy states that concern expressed from carers should be taken seriously and should lead to the care coordinator considering the need to initiate a review. The CPA Policy states that 'Carers form a vital part of the support required to aid a person's recovery. Their own needs will be recognised and directed for assessment through Adult Social Care in accordance with the Care Act 2014'.

In June 2024, the Trust ratified a new Personalised Care policy in response to changes in national policies and guidance such as the NHS Long Term Plan; NICE Clinical Guideline NG 197 – Shared Decision Making; along with the delivery of local transformation plans and the move away from Care Programme Approach (CPA) as directed by the Community Mental Health Framework.

The DHSC (2009), document suggests a summary of all risks should inform '…formulations of the situations in which identified risks may occur, and actions to be taken by practitioners and the service user in response to crisis.' Assessing and managing risk in mental health services - GOV.UK (www.gov.uk)

Later in this same document it notes that most risk assessment tools do not assist practitioners to evaluate the effectiveness of 'protective factors' (controls) to derive formulations.

The Royal College of Psychiatrists guide (2016) offers a list of questions for clinicians to ask themselves to support the process of risk formulation that considers patient's personality, history, mental state, environment, protective factors (controls) and recognise changes with any of these.

7.4.3 VC's first contact with mental health services

VC first became known to mental health services in May 2020 when he was arrested for criminal damage to a neighbour's flat and a Mental Health Act (MHA) assessment was requested. He had symptoms to suggest that he was experiencing a psychotic episode with paranoid delusions which he had acted on.

An MHA assessment was undertaken, and it was concluded that, because VC was willing to engage with mental health care and treatment in the community, he should be discharged home under the care of the Crisis team.

A risk assessment was completed by a mental health nurse before VC was released from police custody. In terms of risk formulation, the form documents that VC had no history of mental health difficulties. Nor a history of illicit substance use or a history of violence and aggression. It was documented that VC had been hearing voices and believed his mother was in the flat that he was trying to gain access to. He reported that he had a lack of sleep during the past week and had been feeling the pressure from his studies.

With VC's consent, he was referred to the Crisis team. The Crisis team received VC's referral and planned to visit him the same day after his release from police custody. This timeframe is in line with Trust and national guidance Royal College of Psychiatrists (RCPsych) best practice guidelines which states that very urgent referrals should be seen within 4 hours and urgent referrals within 24 hours. However, before the Crisis team visit took place, VC was back in police custody for again trying to enter a neighbour's flat.

VC's family told the independent investigation that they asked if VC could be held until they arrived to take him home with them. However, they were told that this was not possible as the Police had no grounds legally or based on his Mental Health Act assessment on which to hold him.

The decision to discharge VC to the care of the Crisis team was in line with the Mental Health Act (MHA) 1983 Code of Practice guidelines to ensure care is person-centred with the least restrictive interventions as possible. Whilst it is not documented as a management plan for risk, the factors to mitigate risk were prescribing VC medication (Olanzapine 2.5 mgs at night and Zopiclone 7.5 mgs at night) and for urgent follow-up with the Crisis team. However, the medication was not administered whilst in custody and the plan was for the Crisis team member to bring

the medication with them when they visited VC at home later that day. This is standard practice in such circumstances.

Comment

The independent investigation acknowledges that this was VC's first presentation to mental health services, an assessment was conducted and, in line with least restrictive practice, a decision was made to discharge VC. However, the accompanying risk documentation did not fully explore risks of returning VC to an address where he had just been arrested for a suspected offence or document a clear management plan. The mitigating factors were medication and Crisis team input however he was rearrested for a similar offence before either of these mitigations had been put in place. The balancing of least restrictive practice against the risk to the individual and others needs to be undertaken with a thorough understanding of hazards and risk factors.

Finding

The independent investigation considers that the actions were appropriate (medication and urgent referral to the Crisis team) but the actions did not happen within a timeframe that would mitigate recognised risks associated with VC's symptoms.

First hospital admission 24 May 2020 – 17 June 2020 (25 day stay)

When VC was arrested for a second time that day a second MHA assessment was conducted, and he was subsequently detained under Section 2 of the MHA. This section enables a hospital admission for up to 28 days to allow for an assessment of whether the person is experiencing a mental disorder, the nature of that disorder and to observe how they respond to treatment.

During this first admission VC was treated under the Care Programme Approach (CPA). Factors which influence whether an individual needs to be managed under the CPA include whether their mental health problem is considered to be severe and if they have recently been detained under a section of the MHA. Evidence suggests that VC met both criteria. The parameters of the policy and national guidance is detailed above in section 6.4.2 (National and local guidance).

Under the CPA, an individual is allocated a care coordinator, and a care plan is drawn-up. The care plan sets out what support they will receive on a day-to-day basis and who will provide this. The care plan should also outline any risks, including details of what should happen in an emergency or crisis. The CPA care coordinator should see the individual regularly and manage the care plan and review it at least once a year.

Comment

It was appropriate that VC was identified as needing to be cared for under the CPA given his presentation with a severe mental health condition and the fact that he had been sectioned to allow a period of assessment.

Whilst VC was an inpatient within Trust services, his care would have been guided by the Trust's 'Service Guide: Adult Mental Health Acute Inpatient wards'. The document states: 'Comprehensive assessment and formulation of patient's needs inclusive of risk, is an ongoing process throughout inpatient stay…Risk assessments are to be completed on admission and dynamically following this to ensure these

assessments demonstrate current risks. A minimum expectation for review is monthly'.

A risk assessment was completed two days into VC's admission and two days before he was discharged. The frequency of the risk assessments whilst VC was an inpatient on this occasion was in line with the Trust's service guide. At the time that VC was known to mental health services, the Trust did not have a Trust-wide clinical risk management policy in place. Instead, each service had its own individual risk management policy. This is at odds with the 2009 national guidance Best Practice Managing Risk Cover (publishing.service.gov.uk) which states that risk management requires an organisational strategy as well as efforts by the individual practitioner. This frames the challenge often described by clinicians and organisations in treading the difficult line between treatment and rehabilitation that inherently carries a degree of risk with the liberty of the individual and the risk to them, through inadequate delivery of treatment, and to others.

In terms of the content of the risk assessments and management plans, best practice guidance stresses 'Risk management plans should be developed by multidisciplinary and multiagency teams operating in an open, democratic and transparent culture that embraces reflective practice.'

Both VC's assessments were completed by a ward nurse and the assessments appear to draw on information discussed during MDTs, ward rounds and interactions with VC during his stay. Both assessments identify that VC posed a risk to others through either aggression, violence, associated criminality, exploitation, abuse or neglect of others.

Finding

A lack of Trust-wide clinical risk management policy and approach to risk formulation meant that risk assessment was not based on best practice or consistently applied across different clinical settings.

Comment

VC was discharged from his first inpatient stay on 17 June 2020 (25 days after being admitted), with a diagnosis of first episode of psychosis. The independent investigation acknowledges VC appeared to recover quickly once he was concordant with regular medication. VC also provided assurance to staff that he was willing to engage with ongoing care in the community and take his medication. Therefore, in line with least restrictive practice, inpatient staff made the decision to discharge VC into the community to continue treatment. However, the accompanying risk documentation did not fully explore hazards and related risks, warning signs for relapse and safety plans to help support VC to stay well.

Additionally, whilst conversations with VC's mother and the University were recorded in the clinical records, it is not clear how their views and input influenced VC's care and safety planning.

The independent investigation acknowledges that this first admission took place when the UK was in a national lockdown during the first phase of the COVID-19 pandemic and no vaccines were available. Services were required to make considerable adjustments to how they delivered care and treatment during this period. We interviewed staff to understand the way in which care and treatment on the ward differed under lockdown conditions. During this admission family and carers were unlikely to have been allowed onto the ward but were able to take part in meetings remotely. Patients were able to continue to move around the ward and use communal areas.

During interviews, staff described a huge pressure because of reduced staffing levels. Staff described real difficulties in filling the shifts with the appropriate number of staff due to sickness and staff required to shield. During interviews, evidence was presented that staff were experiencing a more stressful environment as a result of increasing pressures. We heard about a level of chaos and disorganisation on the in-patient wards:

> "At the time as well, just to mention, the ward was very chaotic. We would have been full. I wouldn't be able to tell you the exact numbers of admissions and things like that at the time, but the ward was very chaotic and we definitely had some patients on the ward that were very loud, quite aggressive and, at times, would have been racially abusive.[15]"

This evidence is supported by Trust board meeting minutes from that period that describe depleted staffing numbers as a consequence of sickness and absence. This was noted as resulting in an increased use of out of area independent provider beds and an increase in use of temporary and agency staff. Board minutes from this time also suggest concern for quality and safety. This pattern continued until VC's final inpatient stay in February 2022 and staffing capacity was identified as an organisational strategic risk.

The insight into potential consequences further down in the organisation and the risks to be managed by frontline staff appear less visible in organisational communications.

7.4.4 First episode of community care 17 June 2020 – 13 July 2020

VC's section was rescinded, and he was discharged back into the community to engage with mental health services on a voluntary basis. VC was initially placed under the care of the Crisis team because he was undecided on whether he was going to remain in the area or move back to Birmingham. It was agreed that the Crisis team would manage his care until a decision was made. If he was remaining in the area, he would be referred to the EIP team.

VC's family raised concerns that most meetings between VC and the Crisis team were by telephone. VC's family felt that face to face meetings would have allowed for a more thorough assessment of VC's mental state and provide less opportunity to

[15] Transcript of a ward team leader.

minimise any symptoms. It is acknowledged that the UK was in a national lockdown at this point and the Crisis team were having to make risk-based decisions regarding who received a face-to face meeting. However, the rationale for VC being assessed as suitable for telephone meetings was not shared with VC's family at the time nor was it documented in VC's clinical records.

After 15 days VC was transferred to the care of the EIP team because he had decided to remain in the area. A joint meeting took place between VC, the Crisis team and Care Coordinator 1 from the EIP service ahead of the transfer of care.

There are two national models for EIP service delivery, either a stand-alone service or a hub and spoke model. In a stand-alone service, the team works independently from the generic community mental health teams and care coordinators assertively outreach to people when they are experiencing first episode psychosis. According to the NHS England guidance eip-guidance.pdf (england.nhs.uk) there is a clear evidence base for the delivery of EIP as a stand-alone model. The research has demonstrated that this model is more clinically and cost-effective, and better able to implement NICE-recommended interventions. It is also recognised as providing higher quality and effectiveness of care.

The hub and spoke model is one where some EIP staff members ('spokes') are based within generic CMHTs and link to an EIP 'hub' for access to specialist skills, support and supervision. The guidance states that the evidence for these teams is limited and there are significant risks associated with this model, including:

- isolation of EIP workers
- limitations in clinical supervision
- lack of availability for trained therapists
- issues with travel time
- abrupt or gradual increases in caseloads.

When VC was under the care of the EIP team at this point, it was part of the local mental health team, the less clinically and cost effective of the two models described in the guidance. Interviewees told the independent investigation that there were positives and negatives associated with the EIP pathway being delivered in this way. Positives included access to wider support services such as psychology, occupational therapy, and administrative support but one of the negative factors was that care coordinators did not have a dedicated caseload of service users on the EIP pathway.

Finding

Organisational decision making within the structure of mental health services did not appear to take account of national insights relating to service effectiveness and efficiency.

The national guidance states that on entering the EIP, a care plan in collaboration with the service user, should be compiled as soon as possible following assessment, based on a psychiatric and psychological formulation, and a full assessment of their physical health. **[2009, amended 2014]** ' Recommendations | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE. In VC's case, after the joint meeting between VC, the Crisis team and the EIP team there was one further face to face appointment and two telephone contacts between VC and Care Coordinator 1 before his further deterioration, and subsequent detention under the Mental Health Act, two weeks after his care was transferred to the EIP service.

VC's mother contacted Care Coordinator 1 to raise concerns about her son's deteriorating mental state within the first week of VC being under the care of the EIP service. She was concerned that he might not be taking his medication. Whilst Care Coordinator 1 attempted to return the call to VC's mother on two occasions, there is nothing in the records to suggest that further contact was made with VC to assess whether his mental state was deteriorating. Four days after VC's mother contacted

the EIP team, VC was arrested for again forcing his way into someone's flat and was subsequently detained under the Mental Health Act.

Finding

The voice of VC's family was not effectively considered to support the dynamic evaluation of risk.

The national guidance **[2009, amended 2014]** ' Recommendations | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE states that a comprehensive multidisciplinary assessment of people with psychotic symptoms in secondary care should be carried out. This should include assessment by a psychiatrist, a psychologist or a professional with expertise in the psychological treatment of people with psychosis or schizophrenia. There was limited opportunity for such an assessment to take place by the EIP team with the limited contact over the two weeks VC was known to their service.

The Trust's EIP operational policy was the reference document that guided the management of risk for VC's care when in the community. This policy references the need to record formulation of risk and '…plans put in place which covers risk, actions, time frames, contact method...'

Comment

VC was in the community for less than 28 days before he was readmitted to hospital due to a relapse and the presence of psychotic symptoms. During his time in the community VC had two weeks under the care of the Crisis team and two weeks under the care of EIP. He was voluntarily engaging with mental health services and whilst he reported to be taking his medication it subsequently transpired that he had stopped taking it within two weeks of being discharged from hospital.

Finding

During VC's time in the community risk assessments and care plans were not completed which meant there was little documented understanding of the hazards which impacted on the risks to VC's mental state and his risk to others. National guidance suggests that such assessments should be completed as soon as possible on entering a service. The risk management plan should also be revisited before and during time periods that are recognised to be associated with increased risk, for instance, prior to leave, on return from leave and around the time of discharge and around the time of discharge or transfer between services, particularly if the level of security provided is changing in line with best practice guidance (*Best Practice in Managing Risk : Principles and Evidence for Best Practice in the Assessment and Management of Risk to Self and Others in Mental Health Services*. London: Department of Health, 2007. (Updated, 2009)) The investigation could not establish why such assessments were not undertaken but the independent investigation acknowledges the high workload being experienced within the team at that time.

Second inpatient admission 14 July 2020 – 31 July 2020 (17 day stay)

VC's second admission came at a time when the UK was just coming out of a national lockdown and COVID-19 was still considered to present a real risk to the public. The impact that COVID-19 and other issues were having on staffing and care delivery are detailed in the assurance and oversight section of this report.

VC's care during this second admission continued to be under the CPA, in line with local and national guidance.

A care plan was completed whilst VC was in the 136 Suite awaiting a Mental Health Act assessment. The care plan documented actions that needed to take place, such as seeking VC's approval to discuss his mental state and care plan with his family. The timeliness and content of the care plan was in line with the good practice guidance.

The outcome of the MHA assessment was that VC was sectioned under a Section 3 (for treatment) of the Mental Health Act. Under a Section 3 patients can be detained for up to six months in the first instance. Where necessary, this can be renewed for a period of six months and then for ongoing periods up to 12 months where required.

A further care plan was completed the following day, when VC was admitted to a ward under Section 3. Regarding VC's view on recovery the document states VC 'appears to lack insight into his current presentation. Therefore, it is unlikely that he understands the need for recovery. Staff will need to support him so that he can be compliant with treatment to enhance recovery'.

A risk assessment was also completed that day. Under the risk formulation it is documented that he 'appears to be responding to Auditory hallucination. [VC] seemed to be responding to unseen stimuli.' On the same day, a 72-hour ward review took place. In terms of 'risk to others', it was documented that '…there have

been no incidents of violence yet, but this would be a potential concern if acutely unwell.'

On the ward review form under 'patient comments' which is a summary of the discussion recorded by the junior doctor it states that: '[VC] describes stopping medication two weeks after discharge from his last admission because he read that it could 'slow the mind'. He concedes that doing so may have 'made me a little more paranoid'. Seems non plussed when confronted with the effects of his behaviour with the neighbour during this incident and also the previous admission. No signs of remorse or insight into how his actions have affected others. Just says 'there will not be a next time'. [the ward consultant psychiatrist] observed that there seems to be no insight or remorse and that the danger is that this will happen again and perhaps [VC] will end up killing someone. [VC] simply responds by saying 'it will not happen again'. The doctor documented that the Police are not intending to press charges.

The independent investigation asked the treating consultant about this entry in the records. The consultant reported that the comment was not documented in the context in which it had been made. The treating consultant was talking with VC about lack of insight and the need to take medication. He talked to VC about the injury to the woman who jumped out of her window when VC entered her flat and said that, if that were to happen again, next time VC could inadvertently kill someone. The treating consultant told the independent investigation that the intention of the comment was to convey the seriousness to VC of not taking his medication.

The treating consultant told the independent investigation that they never formed an opinion that VC would kill someone through a direct act of violence. They said that if that had been their impression then their management of VC would have been different. It would have included a referral to forensic services, engagement with the police and a risk management plan which reflected that level of risks.

A further care plan was completed on 28 July 2020, three days before VC was discharged from hospital. Most of the document is cut and pasted from the previous

care plan completed at the first admission. There is an additional paragraph about discharge which states that the provisional plan is for VC to be discharged back to his accommodation but there is the possibility that VC may return to his family home out of area. It also states that an MDT will consider Crisis team involvement on discharge. No further risk assessments were completed during his inpatient stay or upon discharge.

Finding

VC's care plans and risk assessments were duplicated with few additions or modifications. This suggests that completing such documentation was perceived necessary for record keeping rather than a meaningful, active opportunity to review hazards, risks and effectiveness of controls across different care settings.

There were discussions regarding how best to manage VC's risk of relapse within the community such as consideration of depot medication. However, these hazards and the risks they could lead to are not documented in the risk or care plan documentation.

On 31 July 2020, after VC's Section 3 was rescinded, VC was discharged back into the community with a plan for him to be followed-up by the Crisis team before continuing his voluntary engagement with EIP.

A discharge summary was completed and sent to VC's GP. The letter states that VC 'assures us that he fully understands the importance of taking medication and he has developed greater insight into his illness'. As this is his second episode as an inpatient it was concluded that VC is most likely experiencing paranoid schizophrenia.

VC's family were included in ward discussions and their voice is represented in VC's clinical records. However, the family do not feel that sufficient attention was paid to their concerns or their thoughts on treatment and management options for VC. The

family expressed concerns that VC's second admission only lasted two weeks despite a Section 3 allowing for an initial treatment period of up to six months. They felt this was a real missed opportunity to fully understand VC's diagnosis, risk and to get to grips with a treatment plan that VC was concordant with. VC's family felt at this point there was no long-term plan to manage VC's lack of insight, engagement or lack of concordance with medication. Further consideration of the use of sections is discussed later in this report.

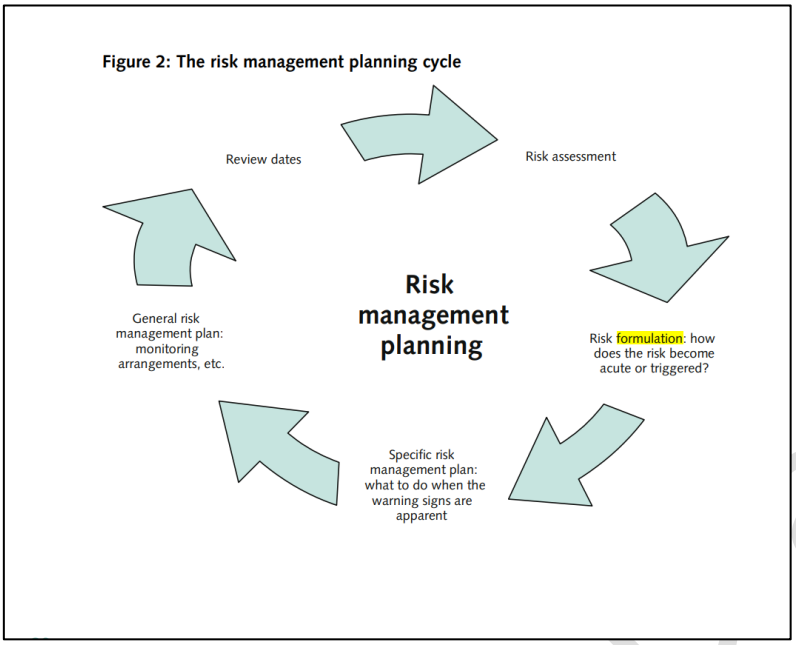
Comment

VC's family told the independent investigation that clinical staff informed them that they do not like to keep people in hospital for longer than they should and getting people back into the community has a better outcome, even though, in VC's family's view, VC always maintained that he was not mentally ill. VC's family felt that staff did not consider that his lack of engagement on the ward was likely to result in continued lack of engagement within the community.

Care plans and risk assessments were completed on VC's arrival into inpatient services for his second admission. However, as with the first admission they primarily focus on listing the events which led him into hospital. They do not contain details under the crisis contingency/safety planning section or any real formulation.

A risk assessment that is purely a list of relevant factors considered as relevant to an individual likelihood of an adverse event or high harm outcome is of limited use to facilitate decision making and relevance to the context being considered (Nathan and Bhandari, 2022).

The figure below demonstrates nationally recognised best practice in risk management planning. The risk documentation in VC's case does not appear to be in line with this.



Best Practice Managing Risk Cover (publishing.service.gov.uk)

7.4.5 Second episode of community care 31 July 2020 – 3 September 2021

When back in the community, VC continued to be managed under the CPA. This was in line with local and national guidance.

Between discharge from hospital and 6 August 2020 VC was seen by members of the Crisis team with a view to support him taking his medication. Following a joint visit between Crisis, VC and the EIP Care Coordinator 1 on 6 August 2020, VC's care was handed over to the EIP team on 13 August for VC to engage on a voluntary basis.

On 1 September 2020, Care Coordinator 1 completed a care plan. Under the section on Crisis Contingency Plan/Safety Plan, they documented:

- VC should access his own coping strategies in the first instance and seek support from family and friends.
- If VC requires further support or should a crisis arise, he can access support from Care Coordinator 1.

- If Care Coordinator 1 is not available during working hours, VC can contact the mental health team duty worker.
- Should support be required outside of these times contact can be made by the Crisis team.

Comment

Completion of a care plan at the point that VC's care was transferred to the EIP team was in line with good practice guidance. However, the crisis plan puts significant emphasis on VC accessing his own coping strategies, but it is unclear what these are or whether he would have the insight to recognise that he was in crisis and needing to access support, particularly given his limited insight into his mental health condition.

On 29 June 2021, another care plan was completed. This document is largely the same as the care plan completed on 1 September 2020.

The first risk assessment that was completed during this episode of care was on 31 August 2021, 13 months after VC was discharged back into the community and at the point where his mental health had deteriorated to the point where Care Coordinator 1 considered that VC was relapsing. In line with national guidelines, risk assessments should be completed when there has been a change in circumstance. This would often be considered at the point when care moves from one service to another. Additionally, there were points during the year where it could be considered that VC's circumstances or mental state had changed sufficiently to warrant a review of his risks. For example, when VC was described by an EIP worker as being psychotic in November 2020 and when the family began to raise concerns about VC's mental state deteriorating from the end of May 2021.

Finding

It was good practice that VC's risk was reviewed at this point as it was recognised that there had been significant deterioration in VC's mental state and that this could impact on the risk he posed to himself and others. However, there were potentially earlier opportunities to review VC's hazards and potential risks and create a safety plan to support VC to remain well and help him recognise deterioration.

During this second episode of community care, in 2021 the Trust decided to 'uncouple' the EIP from the Local Mental Health Team[16] (LMHT) and move to the stand-alone model of care as described above.

A subsequent independent review of the EIP service established that the move to separate out the EIP service was made because the service was not meeting expected standards and targets. In the new service model, care coordinators were released from LMHT duties and allocated EIP caseloads and consultants were allocated sessional time with the EIP team. The report identified that dedicated administrative, psychology, social work and occupational therapy time was not part of the core offer from the EIP team. If needed it was possible to source this through the LMHT, however, that review team, and this independent investigation, were told that this rarely happens because of the limited capacity of those specialties to support the service. The EIP consultant has three sessions a week dedicated to EIP which equates to a day and a half. If EIP cover is needed outside of those sessions, cover is provided by a colleague in the LMHT, they provide cross-cover for each

[16] The local community mental health team is a multidisciplinary team of health and social services professionals(psychiatrists, social workers, community psychiatric nurses, psychologists and mental health therapists), which offers specialist mental health assessment, treatment and care to people with severe and/or longterm mental health problems in their home or community, rather than in hospital.

other. The EIP consultant also has two other sessions with a different cohort of patients but can be contacted about EIP patients if necessary.

On 18 January 2021 a relapse prevention plan was completed between VC and Care Coordinator 1. It was documented that when he first starts to become unwell, he notices:

- having unusual thoughts, beliefs
- Feeling like he was being watched
- Noticing coincidences
- Everything seeming meaningful

Then…….

- Feeling depressed and low
- Feeling violent / angry / aggressive or pushy (although never acted on these feelings.
- Thinking my thoughts might be controlled.
- Feeling tense / anxious and afraid.
- Feeling distressed

The documented ‘relapse drill’ when VC notices being unwell is documented as:

Step 1 - Stay calm- go for walk, watch a video, stay active, breathing exercises, medication

- Contact Keyworker/ Co keyworkers- discuss how you feel
- Make time for yourself/ use the support of your family and friends
- Try to cope with thought problems ie:

  • What is the thought? Write it down
  • What is the evidence?
  • Are there any other explanations?
  • Is there a different way of viewing the thought?
  • Pros and cons- select best solution

Step 2 - Distraction techniques

- Increase contact with key worker if necessary (discuss feelings/ reality testing)
- Request PRN medication if you think it might be helpful.
- Contact Doctor re: increasing or recommencing medication
- Try to reduce any environmental stressors (workload, being alone etc)
- Concentrate on positive images, nature, greenery
- Use coping strategies, reading and listening to music.
- Count backwards from 100 in 13's
- Stop and think before you act

Step 3 - Intensive community management

- Discussion with yourself, family and professionals to consider options
- Increase to daily or more contact by EIP
- Refer to CRHT for out of hours contact
- Admission always as a last resort

In June 2021 a crisis and contingency plan was put in place. The care plan at that time suggests that VC's family inputted into the document, but the family voice does not appear to be present in the document. In terms of the contingency plan the document says:

- VC should access his own coping strategies in the first instance and seek support from family and friends.
- If VC requires further support or should a crisis arise, he can access support from care co-ordinator or from the EIP.
- Should support be required outside of these times VC can contact the Crisis team at evenings, nights, weekends or bank holidays.
- In event of a crisis, the Mental Health Team will consider increasing the frequency of contact with VC to assess risks and to support him in a timely manner.

- Consider Home Treatment if this is safe for VC, involving the Crisis team where appropriate.

Finding

There is significant emphasis placed on VC recognising his own deterioration in his mental state and then seeking support. Given VC was documented throughout his care to have limited insight into his mental health this may have been difficult for VC to do.

VC's family told the independent investigation that three months prior to VC's third admission they could see that he was deteriorating and that they flagged their concerns to mental health services. Staff subsequently visited VC and reported back that they had no concerns about VC's current mental state.

VC's family also report identifying a pattern to VC's behaviour when he was deteriorating which was evident to them at the time. The pattern included VC being irritable and withdrawn, masking symptoms and failing to attend appointments. The family believe that they recognised the signs of relapse in May 2021, but it was not until August 2021 that mental health staff felt that VC was experiencing a relapse in his mental health condition.

Finding

VC's family recognised signs that he was experiencing deterioration in his mental health in May 2021 and staff subsequently visited him but did not consider his presentation to be suggestive of a relapse. The notes suggest that the voice of VC's family does not appear to present as equal to the clinical perspective in VC's deterioration.

Comment

The EIP pathway is based on voluntary engagement by patients with care and treatment plans. The ability for staff to locate and observe VC to identify changes in clinical presentation and evidence of concordance with medication created a tension for staff to understand the level of risk and dynamic changes that might be possible with greater frequency in engagement. This needed to be balanced with VC's recognised hazards of masking of symptoms, lack of insight and non-engagement which led to the risk of inability to review and understand the dynamic risk presented by VC's mental health condition.

7.4.6 Third inpatient episode 3 September 2021 – 22 October 2021 (48 day stay)

On 31 August 2021 Care Coordinator 1 and a colleague visited VC at his home due to concerns that he may be relapsing, their concerns were confirmed during this visit, and they requested MHA assessment. During the MHA assessment VC significantly assaulted police officers who were there in support. VC required tasering followed by pepper spray to restrain him. He was removed from his flat and taken to the 136 suite and then detained under Section 2. He remained in seclusion in the 136 suite for nine days while a PICU bed was located. VC was subsequently admitted to a PICU at an out of area independent provider. The records from this stay suggest that his care was documented and decisions around treatment were discussed as an MDT.

On 11 September 2021 a risk assessment was completed. VC's risk of harm to others was documented as 'medium' and in the comments it is documented:

> 'High risk of violence and aggression, nursed in seclusion for the last week…Due to extreme levels of violence and aggression, physically assaulting a police officer by punching him on the face and attempting to assault other, an emergency shout for support went out from Officers on scene executing the S135 warrant, dictating that they were being assaulted and needed extra support.'

A further risk assessment was completed on 14 September 2021 but there were no changes or additions from the assessment completed on 11 September 2021.

Care Coordinator 1 raised with the independent provider the possibility of VC being moved to depot medication given his history of non-concordance in the community. They were told that there were no plans to move to depot medication at that point (in the PICU) but that VC's needs for the community would be considered when he was stepped down from the PICU. The independent provider told the independent investigation that during his admission, VC accepted his prescribed antipsychotic medication but refused the offer of depot medication. However, depot medication was considered to be of benefit to VC in the longer term

Comment

There is no evidence to suggest that Care Coordinator 1's concerns about managing VC within the community were fully considered in the risk and care planning during this third admission.

A third risk assessment was completed on 21 September 2021, it is the same as the previous two but adds that VC had not shown any aggression or violence towards others since admission, he had been concordant with his medications since admission and that he had not tried to leave without permission.

VC was moved from the out of area independent provider PICU to an acute adult inpatient ward with a different independent provider on 1 October 2021.

A risk assessment was completed on 21 October 2021, the day before he was discharged back to the community. VC's risk was assessed to be low in all areas. He was marked as a medium risk for historical non-concordance with medication, and historically high risk for self-neglect, violent, aggressive, intimidating behaviour and for absconding or escape. Under 'other risk factors' it is recorded that VC 'May be able to mask symptoms to get discharged. Circumstances of current admission has been

serious and violent'. Under patient views it is documented that VC was 'Presenting as relaxed, engaging better during ward review, showing insight but appears to be in denial of the severity of illness.'

A 'keeping safe care plan' was also completed on this date. Current risks were documented as:

- Non-compliance
- Violence and aggression
- Psychosis
- Paranoia
- Harassment of neighbours

A 'keeping well care plan' was also completed on 21 October 2021. In terms of how VC meets his goal of wanting to be discharged, it is documented that he needs to:

- be compliant with his medication
- seek help in times when he realises he is struggling with his mental state
- engage with the nursing team

VC's family told the independent investigation that during VC's third hospital admission, VC's mother tried to engage with the ward and with VC but was told that he did not consent. From that point, VC's family felt it was difficult to engage with the ward to establish VC's mental state or to share information.

VC's family told the independent investigation that they only learnt of VC having been discharged when VC's mother called the hospital for an update on VC's progress. Trust records suggest that the EIP service were also unaware of the discharge that day, however the records of the independent provider state that the service was informed and a date for a 72-hour review was arranged.

Finding

A number of assessments took place during VC's third hospital admission, however they did not look longitudinally at the pattern of VC's behaviour when in the community verses when an inpatient. The subsequent associated risks could not be fully understood as his care was being seen in isolation and assessed based on his presentation upon recovery after medication concordance. This is despite a significant, violent assault on police officers preceding this admission.

It was the view of Care Coordinator 1 that VC would benefit from depot medication as a way to support concordance in the community. Despite being the clinician who had the most contact with VC and over a prolonged period, their views were not seen to be acted on.

Additionally, VC's family were not utilised as an important source of information to help seek to understand the patterns of VC's mental illness. Nor were his family engaged to help support to mitigate hazards recognised in the community of symptom masking, low insight and non-engagement and seek to reduce escalation and need for a physical restraint by Police.

7.4.7 Third episode of community care 22 October 2021 – 28 January 2022

There were no updates to VC's care planning or risk assessment documentation during VC's third episode in the community. From 19 November – 16 December 2021 the EIP were unable to contact VC. When he made contact on 16 December 2021 VC was documented as being 'angry and confrontational' and told the EIP team not to contact his mother.

VC's mother had been contacted to try to establish VC's whereabouts because of his non-attendance. VC's family told the independent investigation that they were concerned about VC's lack of engagement with the community team. The family

report that VC began to show signs of deterioration within three weeks of being discharged from his third admission – masking symptoms, non-concordance with medication, missing appointments and being hostile and non-engaging during appointments.

VC collected his medication on 17 December 2021 and was documented as being 'curt with the receptionist and having a hostile edge to him'. VC failed to attend any further appointments (four were scheduled) or answer the phone throughout the end of December 2021 and into January 2022.

In mid-December Care Coordinator 1 texted VC's mother to inform her that VC had asked that the EIP team have no further contact with his family. VC's family felt this left them largely unaware of what was going on for VC in terms of his care and treatment and therefore made it hard to identify and flag concerns to the service.

On 18 January 2022, Care Coordinator 1 received information from the University with details of an incident involving another student the previous day.

The student who was VC's flat mate stated that VC had assaulted him and trapped him and their other flat mate in the flat requiring the Police to be called. The reporting student stated that the Police had told him that although VC had intent to hurt him, because he (the reporting student) had stopped VC by grabbing and holding him and he (the reporting student) had not sustained any injuries, they could not arrest VC. The University expressed concerns about VC's presentation and him remaining in the accommodation.

Comment

When VC disengaged from services in November and December 2021, this could have potentially been an appropriate time (in line with guidance) to review VC's care plan and risk assessment. Another opportunity to review risk could have been when the EIP service received information regarding the alleged assault on flatmates.

VC acknowledged in earlier relapse prevention plans that getting angry and frustrated was a sign his mental health may be deteriorating. He was exhibiting these signs in his minimal contact with EIP staff. However, this did not lead to reassessment of VC's mental state or risk.

There were some positive attempts to proactively engage with VC's family particularly from Care Coordinator 1 who did, at times, appear to have formed a good working relationship with VC but this deteriorated when he became unwell and suspicious.

Additionally, although VC withdrew his consent, EIP staff did try to engage with his family on occasions to discuss issues of risk. For example, when he disengaged from services, and they could not locate him they contacted VC's mother to establish if she knew where he was. However, communication did not always cover important decisions or milestones.

Finding

VC's decision to exclude his family from active involvement in his care and treatment is based on judgment that VC has capacity to have rationalised that decision. It is at odds with the original assessment which views VC's family as a protective factor and suggests his family are valuable to manage known hazards around symptom masking and non-engagement.

On 18 January 2022, there were concerns about VC's mental state. He was noted to be disengaging with EIP and no longer concordant with his medication (Aripiprazole). Care Coordinator 1 had been made aware of an incident the previous night where VC was alleged to have assaulted a flatmate/student. It was documented that:

> 'Due to risks poses to others when unwell (police had to taser him last time, he has taken hostages in his flat, assault) then LMHT [local mental health

team] would not attempt further [home visit] to try engage…Appropriate for CPN [community psychiatric nurse] to call MHAA [Mental Health Act Assessment]. Police will also be requested so can carry out assessment.'

VC subsequently underwent a Mental Health Act assessment in the 136 Suite. He was not detained as he agreed to Crisis intervention with daily visits to supervise medication concordance. VC was managed in the community by the Crisis team for almost a week, at which point they initiated a further MHA assessment after discussion with the community consultant as there remained ongoing concerns about medication concordance, and VC not engaging with the monitoring of his mental state by the Crisis team. This subsequent assessment led to his fourth inpatient admission.

Finding

The efforts to keep VC in the community with close observation by the Crisis team was a positive example of an attempt to be as least restrictive as possible in their management of VC. When the Crisis team were not assured that VC was concordant with his medication or fully engaged in the process, they made an appropriate decision to call for a further assessment under the Mental Health Act.

Fourth hospital admission 28 January 2022 – 24 February 2022 (27 day stay)

VC's risk assessment was updated on 28 January 2022 upon admission to hospital. The risk assessment documented that VC had a 'history of recurrent psychosis' and noted that he had been detained under a Section 2 that day.

A core assessment was completed that day but appeared to just cut and paste previous information relating to VC. A 'summary and care plan' was also completed on that day. There is a brief description of the events which led to VC's detention, but the crisis contingency plan/safety plan was not updated.

During the ward round on 1 February 2022 Care Coordinator 1 asked whether there were plans for alternative medication. They reported that it was unclear what his level of medication concordance was in the community and felt that he would be 'better off' on depot medication. The Doctor responded by stating that VC had refused depot medication earlier in the week. During the next ward round on 10 February the notes state that the Doctor asked Care Coordinator 1 for their views regarding depot medication. They responded by saying that they 'wish that he had the depot during his last admission due to risk of non-compliance with medication'. There was then a discussion around whether a CTO would be beneficial and' the long term consequences of this.'

Comment

Care Coordinator 1's views on medication do not appear to have been fed into VC's risk planning and management. This is the second admission in which Care Coordinator 1 has voiced their views on what would help to support VC's care and treatment in the community and the subsequent actions were not aligned with their views. This further supports the finding that the view of the inpatient responsible clinician appears to carry more weight than the voice of those working with VC in the community.

In the fourth discharge, there was no evidence of the family voice in the decision-making process. By this point, VC had requested that his family not be involved in his care, however the Trust's discharge policy (2020) says:

> 'When a patient is transferred/ discharged to a Trust service, information on the service must be provided by the referring team to the patient, relatives and carers. The involvement of family members is essential even if this is against the patient's expressed wishes. The member of staff giving the information must check what has been understood.'

VC's family told the independent investigation that they were aware he was undergoing a Mental Health Act assessment in January 2022 because the AMHP

contacted VC's mother. However, they were not made aware of the outcome. The notes suggest that VC's treating Consultant contacted VC's mother on 2 February 2022 (5 days after the Mental Health Act assessment). The notes suggest that, prior to this admission, VC's family did not have any particular concerns about VC although he had been phoning them more frequently. It was also documented that VC's mother felt that VC was 'scared of mental health services and feels persecuted by them.' She also expressed some frustration about 'our lack of ability to share information based on confidentiality, but accepted explanations'. It was documented that the plan was to ask VC if his mother could be involved in the ward round scheduled for the next day. However, there is nothing in the notes to suggest this happened and no further contact regarding VC during this inpatient admission.

VC's family told the independent investigation that, they considered that there were sufficient concerns about VC's previous poor engagement, poor medication concordance and lack of insight to warrant a different approach to VC's care and keep him in hospital for a longer period for treatment.

Consideration and the appropriate use of different sections of the Mental Health Act is discussed later in this report.

7.4.8 Fourth episode of community care 24 February 2022 – 22 September 2022

Four days after VC was discharged back to the voluntary care of the EIP team, Care Coordinator 1 undertook a risk and safety assessment. The details within the document are the same as the one completed when VC was admitted to hospital on 28 January 2022 but there is an additional paragraph that states 'Given history of violence and aggression, community appointments to take place at …[EIP centre]. Should home visits be required, no lone working, joint visits recommended. Risks to self currently appear low – no history of deliberate self-harm or suicidal thoughts. Risk of self-neglect when unwell, failing to attend to personal hygiene. Risks to others – Male, diagnosis of paranoid schizophrenia, appears to experience

persecutory delusional beliefs that thoughts can be influenced and controlled by computer systems specifically developed to interfere with the mind…[history] of violence and aggression when detained (significant assault on police officers), violence and aggression towards housemates and refused to let them leave property, poor insight, does not agree that he has been unwell over the last 12 months. Poor engagement with community services, history of non-concordance with medication.'

Finding

Whilst the assessment documents a plan to manage the risk to staff (not conducting home visits) it does not seek to develop a plan to manage the hazards of non compliance with medication and non engagement which could lead to the risk – of deterioration of mental health and potential acts of violence.

VC did not engage consistently with the EIP team. During this period, VC was offered fortnightly appointments. He attended 5 of the 14 appointments to collect his medication but avoided any meaningful interaction with the EIP team. VC attended a medical review with the EIP team consultant psychiatrist in March 2022 but failed to attend the next scheduled reviews in June and August 2022. The clinical records suggest that VC rarely answered his phone or returned messages left by the EIP team.

In April 2022 VC's care was transferred to a different care coordinator for multiple reasons, one of which was the possibility of gaining a new perspective on VC and the potential for him to form a new working relationship, however the situation did not improve. In July 2022, VC told the EIP team by text message that he was abroad and would not be returning until October, however, this information was established to be false within several days through communication with VC's family.

An unscheduled visit was made to VC's address on 4 August 2022 by Care Coordinator 2 and a colleague. Care Coordinator 2 told the investigation that he

considered whether a barrier to their interaction was ethnicity based and he therefore requested that a support worker in the team, who is black join him on the visit. When they attended the address, they identified that the address VC had provided was incorrect. On the same day, the possibility of VC being discharged from EIP back to the care of his GP, due to lack of engagement, was documented in VC's clinical records.

Comment

The independent investigation team asked experts by lived experience about selecting care coordinators based on shared experiences including such things as ethnicity and culture. They told us that the important point is to ask individuals who they would feel would be able to support them in their recovery journey.

Five days later VC requested access to his notes and gave a different return address. Care Coordinator 2 subsequently wrote to VC at this new address on 17 August 2022 to try and arrange a meeting but did not receive a response. The following day, at the team weekly review, VC's request to have a copy of his clinical notes was discussed. It was also acknowledged that he had not been supplied with medication for several weeks. It was documented on 31 August 2022, that Care Coordinator 2 considered arranging a home visit which did not take place.

Comment

There is no consideration documented in the clinical records that VC requesting access to his notes may have been his attempt to make sense of his mental health and what was going on for him. Whatever the reason, there is nothing in the records to suggest this could have been indicative of something important.

The next entry in the clinical records was in reference to an MDT meeting that took place on 22 September 2022 where it was determined that 'as no contact has been made with VC for a period of time…., decision made within the team to discharge

back to GP due to non-engagement with view for GP to refer back to services in the future if needed.'

The last contact the EIP service had with VC was eight weeks earlier on 18 July 2022 - the text message exchange in which VC told the EIP worker that he was out of the country and not likely to return until October.

VC was discharged from the EIP service back to the care of his GP on 23 September 2022. No healthcare worker had contact with VC from the point of discharge until the tragic events on 13 June 2023.

Comment

Due to multiple factors, including workload, the discharge system did not function as intended.

7.4.9 Summary of factors which impacted on the delivery of VC's care and treatment

The care delivered to VC should be considered within the context of high demand on services, this includes limited inpatient beds, limited capacity and high demand for Crisis team support and an EIP team with high caseloads and policy expectation which outweighed available resources.

The ability of the service to proactively support people in the community primarily relies upon high levels of resources and actions to support engagement in the least restrictive way and through a positive risk-taking approach. In the absence of resources to deliver such a high intensity model of care, it raises the question whether a positive-risk taking approach can be maintained in cases where risk is unknown because a person is not attending appointments. There does not appear to be a clear perspective in the guidance regarding organisational resources e.g. the need for staffing levels to inform clinicians' risk appetite and where resources are insufficient, recognising that there may be the need to shift from 'positive risk taking'

to a dynamic risk approach to prioritise mitigation of risks. In VC's care, his lack of visibility to staff and therefore their inability to assess his risk became the greatest risk.

There were a number of factors which impacted on the services' ability to deliver VC's care and treatment in line with local and national expectations. These included:

- The impact that COVID-19 and the subsequent restrictions had on the physical environment in which care was delivered in the inpatient setting. Additionally, COVID-19 restrictions would have, to an extent, normalised individuals withdrawing and isolating from others and not engaging in activities.
- COVID-19 and other factors had a detrimental impact on the workforce, this is discussed in the assurance and oversight section of this report.
- Staff had a desire to support VC to study and interpreted that him remaining in his room was a sign he was studious rather than a sign that he did not want to engage or as a symptom of his condition.
- The EIP and CMHTs underwent a restructure during VC's engagement with services which meant a shift to a dedicated team for EIP, however this change resulted in isolation from wider CMHTs and therefore limited their access to some specialties like psychology. However, it is recognised that it was unlikely that VC would have engaged with such interventions with his displayed level of insight into his need for treatment and previously declined to engage with occupational therapy.
- VC's engagement with the EIP team was often erratic over the two years he was actively known to services. After his discharge from inpatient services in February 2022 there does not appear to have been any real, meaningful engagement with VC between then and his discharge in September 2022 despite the efforts of the EIP team.
- The EIP operational policy states the need for staff to take an assertive approach to engage service users. However, the way in which the service is delivered and pressures within the team meant that opportunities to

assertively try to reach out to VC when he disengaged from services were limited.

- Across the Trust and wider system, there were limitations with the ability to collectively understand, assess, document and manage risk. Further, internal and external oversight did not identify these issues or the impact on service delivery.
- Despite the Trust informing the independent investigation that there is mandatory clinical risk training in place, interviewees felt it was not sufficient at that time.
- VC's family's concerns were not always captured and incorporated into VC's care and risk planning. When VC withdrew consent for his family to be communicated with regarding his care and treatment at the end of 2021 this did impact on the way in which staff felt able to communicate with VC's family. However, staff did make attempts to speak with them on occasion, for example when they were trying to locate VC.
- The ability to provide a long-term view on VC's care was impacted by staff appearing to have different priorities and focuses for care. As an inpatient, the focus was on treating the acute crisis and returning VC to the community. However, once discharged VC's community team felt the opportunity to put measures in place to support the treatment of VC had been missed.

In relation to the need for Trust-wide education around risk formulation an interviewee told the independent investigation:

> "…So we broke that down in terms of maybe risk to self in terms of suicide. So all of the staff are doing the new suicide and risk training, which is Trust-wide. So we're all doing that training. We've got those training dates, but also what was really clear, and I think this is clear in some of the other wider learning from the Trust as a whole, particularly to do with mental health, was around actually what does our risk training look like. We have online training. I think it's very different doing face-to-face robust training where you can look at case studies and talk about it."

An interviewee discussed the plan for risk to others training to be delivered:

> "So we are awaiting some official training, either to be brought in or formalised by the Trust, but in the meantime, we've reached out to one of our crisis consultants who has offered some really fantastic risk formulation training to be looking at risk to others."

From the CQC report into Nottingham NHS Trust CQC publishes final part of special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust - Care Quality Commission it is apparent that the need to improve risk formulation and management is not isolated to VC's case. The CQC found from a review of 10 other service users on the EIP pathway that there were inconsistencies in the risk assessment records. They found that in most cases, the EIP team assertively managed patients' psychosis, with risk assessments reviewed frequently and updated in response to changes in a patient's risk profile. However, there were some examples where the 'Risk and Summary Assessment' could have contained more detail and been reviewed more regularly.

The CQC findings acknowledge gaps from the expected standard. However, this independent investigation believes there is still a question to be asked of the effectiveness of the existing national approach to mental health risk management processes. It is beyond the To R of this investigation to explore this complex area, however the investigation received input from national experts and independent clinical advisors who suggested that the effectiveness of risk management may be a wider national problem.

Finding

Clinician's knowledge base on the subject of risk may impact on the quality and value of existing approaches to risk assessment and the content of risk training. It is unlikely that this issue is isolated to services VC engaged with or the Trust.

7.4.10 Care planning summary

VC's care plans did not include active management plans for known hazards such as his medication concordance, his disengagement from services or in light of these hazards, provide support for VC to identify signs of relapse. The clinical picture described by staff included symptoms of paranoia that contributed to VC's level of suspicion of those working in mental health services. This manifested in his belief that there was a conspiracy against him and potential for harm to his family through his engagement with mental health services.

These issues were all factors contributing to the potential risk of deterioration of VCs mental health and potential impact on risk of violence. VC's clinical records suggest that his care and treatment largely aimed to manage known risks through meeting with him to provide medication and to try to engage him for long enough to establish his current mental state. The care delivery was in line with the team trying to be as least restrictive as possible, to try to develop a therapeutic relationship and a desire to support him in his studies. However, without having active plans for the management of his non-concordance, his poor engagement and potential for violence when his mental health deteriorated, it is hard to consider that the care plans fully captured VC's needs or served to manage risk to himself and others. There is limited evidence of scenario planning or safety planning.

One hazard which does not appear to be considered in the clinical notes is the level of isolation VC was likely to be experiencing. Records suggest that he had limited social interactions and interests beyond his studies. Incidents which preceded his detention under the Mental Health Act occurred in the vicinity of his home and, at times, involved his flatmates. This would serve to further isolate him. Offers from EIP could have sought to have considered how to reduce his isolation through ways of involving him within the community. For example, offering peer support to VC with someone who VC may feel able to relate to based on shared experiences.

VC's care plans took account of his views and, when he engaged, VC was involved in the development of his care plans. It is acknowledged by the independent

investigation that VC was often hard to engage, guarded and sometimes provided misleading information to the EIP team which would have impacted on the teams' ability to develop effective care plans.

In line with national guidance to ensure that care plans are fully informed, information should be sought from other sources such as family members and other agencies. Whilst there were, at times, considerable efforts to elicit the views of VC's family, their concerns did not always appear to inform care plans, influence care and treatment and the management of risks. Additionally, there is evidence in the notes of conversations between the Trust and the University, however as with VC's family, it is not clear how these conversations informed care planning and the management of risks.

During VC's four inpatient stays he was generally documented as being quiet and concordant. Whilst he did not engage with ward activities or therapies this was often explained as VC focusing on his studies and working in his room. Documentary and testimonial evidence suggests VC was considered to be studious with the aspiration to complete his degree. Staff adopted a supportive approach to provide a suitable studying environment and the records suggest a reluctance to rush to use diagnostic labels because of the potential impact on long term prospects. This was in line with positive risk management principles. However, the approach to risk assessment does not reflect the risks recognised in the community of non-engagement and masking of symptoms, combined with the potential distressing nature of VC's symptoms that would have made under-treatment a considerable risk to VC's long-term future and potential for harmful events.

Finding

The prioritisation of a positive risk management approach may have impacted the ability to achieve medication concordance, engagement with services and an increased level of insight. Instead, a dynamic approach to risk management would provide the opportunity to consider clear points at which to move from positive risk management to taking a more restrictive approach. This would support the management of hazards as they presented and ultimately support VC with the long-term management of his mental health condition.

The clinical records and interviews with Trust staff suggest VC displayed limited insight into his mental health condition and that he was reluctant to accept his symptoms were a result of a deterioration in his mental health. Staff identified that VC would benefit from interventions such as cognitive behavioural therapy for psychosis (CBTp[17]). VC did not want to engage with any such intervention and the EIP team appeared almost at a loss as to how to work with VC in a way in which would increase his insight into his mental health condition and to fully understand and manage his risk. VC's limited engagement impacted the work that staff within EIP, particularly his care coordinator, could do with him to educate him on his diagnosis, the long-term management plan and the importance of things like taking his medication.

There is a real dilemma and challenge for clinical services and staff to manage service users that engage sporadically and present in such a way that they do not meet specific criteria' to increase restrictive practices or escalate to other services.

[17] CBTp is a structured intervention to assess symptoms of serious mental illness. Similar to other types of cognitive behavioural therapy, CBTp involves establishing a therapeutic relationship, developing an understanding and insight, setting goals and educating a person in techniques and behavioural coping strategies to reduce and manage symptoms.

From the review of documentation and from interviews with staff involved in VC's care and treatment it appears that each admission was seen in isolation with a lack of cumulative perspective of the pattern of concordance and improvement as an inpatient and the lack of engagement in the community. VC appeared to recover quickly from each psychotic episode when an inpatient. Ward staff would experience VC's mental state significantly improve when he was concordant with regular medication. VC would then assure staff that he was willing to engage with the EIP team in the community and take his medication.

The finding suggests that the process of risk assessment focused on the current team's perspective of a selection of risks in a specific context of care. Alternative perspectives based on evidence from other teams and different contexts do not appear to inform the sense making relied upon to support decision making and judgments on management of risks across the breadth of the mental health system. For example, community-based staff told the independent investigation that they believed VC was aware the only way to get out of hospital was to abide by the rules, making it very difficult for him to be kept on a section. This suggests clinicians making decisions on discharge and level of oversight required may not have taken a longer-term view and considered the full picture of the risk VC may pose to himself and others.

When VC was an inpatient, there were a number of opportunities for the community team to discuss VC with the inpatient team, notably at ward meetings and at discharge planning sessions which the community team attended and engaged fully with. However, inter-team engagement for decisions around discharge from one setting into another does not appear to achieve an equal balance between the voices within these different teams. The community team were clearly voicing their professional opinion, that in light of VC's disengagement in the community that a CTO or depot medication should have been a serious consideration (this is discussed later in this report). This is evidenced both in the clinical records and in interviews with the independent investigation. However, the inpatient clinical team very much focused on how VC presented on the ward and appeared to recover

quickly and agree to engage post-discharge. In this case it appears that the voice of the inpatient clinicians carried more weight as on each occasion VC was discharged without any restrictions and the community team had to accept this.

The inpatient setting and the community team have competing demands. The inpatient clinicians' role is to treat the acute episode and prepare someone for discharge back to the community. Whereas the community team have to work with individuals, often on a long-term basis within the community. The inpatient setting has many factors to consider when an individual is an inpatient, often beyond the individual themselves. These include:

- staffing levels to safely manage the number of patients on the ward.
- the acuity of the patients and the mix of patients.
- restrictions (such as the COVID-19 lockdown)
- delivering care in the least restrictive environment, therefore not being in hospital for longer than is considered necessary for their presentation, acknowledging that it is not a trivial decision to deprive someone of their liberty or to enforce treatment.

Comment

The decision making around discharge appeared to suggest a hierarchy of information relied upon in order to make the decision regarding how to manage risks in the community setting. The inpatient clinicians' opinion appeared to carry the most weight, followed by VC's wishes for his care, then the community clinicians and family. However, community clinicians and family were raising concerns about the need for a more formalised approach to VC's care and the need to take more time in hospital to fully understand how best to care for VC

Finding

The current approach to risk assessment does not appear to focus on evaluation and evidence of the effectiveness of the controls in place to manage relevant risks. The clinical judgment made on discharge will have made sense based on observations and conversations with VC at the time. However, in the community context the information inpatient clinicians relied upon to make their decision was contradicted by the observations of staff seeking to engage VC and the family's engagement with VC. The context of care would seem a critical factor for risk assessments completed across inpatient and community teams to understand the implications for the reliability of approaches to risk mitigation and decisions around treatment and discharge.

The way in which risk was being documented and formulated was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings. For example, VC's risk in hospital would have been different from when in the community where hazards such as non-concordance and disengagement from services may have led to risks. The risk assessment's formulation section reads as a list of previous violent behaviour rather than a true formulation and therefore does not demonstrate active risk control or understanding of the impact in change of effectiveness of protective factors. In the community the section of the risk assessment form does not detail the actions taken or needed to attempt to minimise or mitigate known risks. Hence, reviews may not focus on how effective the intended controls were at that time or in the context of the setting.

Finding

There does not appear to be a consideration that non engagement, masking of symptoms due to nature of paranoia and lack of insight are perceived as hazards that contribute to the potential risk of violence. These particular hazards were considered to be more visible and have greater impact and potential for harm in the context of the community care setting compared to the inpatient setting.

7.4.11 Diagnosis and medication

The clinical impression during VC's first contact with mental health services was that VC was experiencing a psychotic episode most likely linked to sleep deprivation and stress. A mental health clustering tool[18] was completed during this first admission and the outcome was that VC was experiencing psychosis under cluster 10 – first episode of psychosis.

A psychotic episode is when an individual loses some element of contact with reality. This might involve seeing or hearing things that other people cannot see or hear (hallucinations) and believing things that are not actually true (delusions). It may also involve confused (disordered) thinking and speaking. Overview - Psychosis - NHS (www.nhs.uk)

Psychosis can be caused by a mental (psychological) condition, a general medical condition, or alcohol or drug misuse. The following conditions can trigger psychotic episodes in some people:

- schizophrenia - a mental health condition that causes hallucinations and delusions
- bipolar disorder - a person with bipolar disorder can have episodes of low mood (depression) and highs or elated mood (mania)
- severe stress or anxiety
- severe depression - feelings of persistent sadness
- lack of sleep

NICE (National Institute for Clinical Excellence) guidelines on first-episode psychosis suggests a number of standard offerings for people experiencing symptoms of psychosis, these include therapy and antipsychotic medication. The guidance states

[18] A cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and then rated using the Mental Health Clustering Tool (MHCT). There are 21 different treatment clusters.

that individuals should be offered CBT (at least 16 meetings) alongside a type of therapy involving their family called family intervention (at least 10 meetings). VC declined any engagement with therapeutic interventions during and following his first admission.

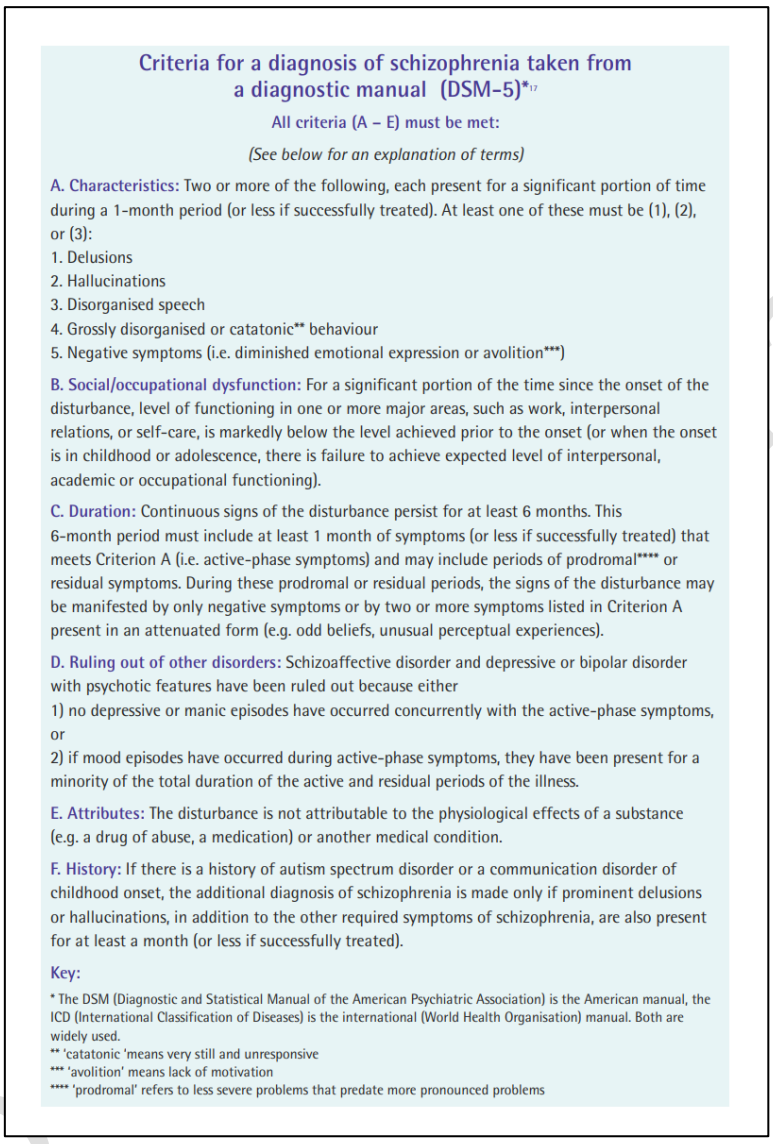
On 17 Jun 2020, VC's responsible clinician met with VC and his mother. He documented that he answered their questions about his presentation, diagnosis of first episode psychosis and explaining why no specific label was used and how this was not useful at this time. The responsible clinician told the independent investigation:

> "He and his mother were quite keen on having some sort of label given to him, and I explained to them that I didn't think labels were important at this present time. It was more important that they understood that what he was experiencing was what we would term a psychotic illness. And this would be something we would call first episode psychosis. And we will see how this condition will evolve over time."

On VC's second admission to hospital, the mental health clustering tool indicated that he was experiencing a psychotic crisis (cluster 14). On 16 July 2020, the inpatient clinical notes suggest that VC has a 'schizophrenia type illness'. By the end of July, towards the end of VC's admission (31 July 2020), the mental health clustering tool documents that VC was experiencing ongoing recurrent psychosis (low symptoms) under cluster 11. However, the clinical records at this time state that clinicians considered that VC was likely to be experiencing a more long-term enduring mental health condition and that his psychotic episodes were being triggered by paranoid schizophrenia.

Paranoid schizophrenia is described as a long-term mental health condition. It causes a range of different psychological symptoms and is often described as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality.

There are clear criteria for diagnosis of schizophrenia under the DSM-5 diagnostic manual. The diagram below documents the characteristics of schizophrenia, two of which need to be present in order for a diagnosis to be made.



Criteria for a diagnosis of schizophrenia taken from a diagnostic manual (DSM-5)*[17]

All criteria (A – E) must be met:

(See below for an explanation of terms)

A. Characteristics: Two or more of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions
2. Hallucinations
3. Disorganised speech
4. Grossly disorganised or catatonic** behaviour
5. Negative symptoms (i.e. diminished emotional expression or avolition***)

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic or occupational functioning).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meets Criterion A (i.e. active-phase symptoms) and may include periods of prodromal**** or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g. odd beliefs, unusual perceptual experiences).

D. Ruling out of other disorders: Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either

1) no depressive or manic episodes have occurred concurrently with the active-phase symptoms, or

2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. Attributes: The disturbance is not attributable to the physiological effects of a substance (e.g. a drug of abuse, a medication) or another medical condition.

F. History: If there is a history of autism spectrum disorder or a communication disorder of childhood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least a month (or less if successfully treated).

Key:

* The DSM (Diagnostic and Statistical Manual of the American Psychiatric Association) is the American manual, the ICD (International Classification of Diseases) is the international (World Health Organisation) manual. Both are widely used.
** 'catatonic 'means very still and unresponsive
*** 'avolition' means lack of motivation
**** 'prodromal' refers to less severe problems that predate more pronounced problems

Schizophrenia is a formal mental health condition that relates to changes in how a person behaves, thinks, and feels. Often a diagnosis of schizophrenia comes following a person's first episode of psychosis. Psychosis is often a symptom of an underlying mental health condition, such as schizophrenia. The term psychosis refers to a collection of symptoms that affect the mind and can make it difficult for a person to determine what is real or not. Whilst schizophrenia can cause psychosis to

occur, psychosis may happen due to other reasons such as sleep deprivation or stress as described above.

Whilst a diagnosis of schizophrenia appears to have been made as early as July 2020, the clinical records, risk assessment and clustering tool documentation continue to refer to VC's presentation as one of psychosis.

During VC's third admission (to an out of area independent provider), a risk assessment document completed on 21 October 2021 states that VC is a '30-year-old gentleman known to services with a diagnosis of psychosis'. However, earlier in his admission (10 September 2021) it is documented that VC 'remains unwell with systematised persecutory delusions driven by first rank symptoms of schizophrenia'.

On 3 November 2021, during VC's third admission it is documented that his diagnosis is paranoid schizophrenia.

A risk assessment undertaken on 28 January 2022 (VC's 4th hospital admission) states that VC is: 'a 30-year-old student of African descent with a history of recurrent psychosis'.

On 17 February 2022 during VC's fourth inpatient admission, paranoid schizophrenia is documented under 'working diagnosis'.

Psychosis treatment usually involves the use of antipsychotic medications and therapies. Antipsychotic medications can help to reduce the intensity and frequency of psychotic episodes, but they cannot treat the underlying condition.

Schizophrenia requires similar treatments to psychosis. However, the treatments approach is often multidisciplinary and involves supervised use of antipsychotic medications, psychotherapy, such as cognitive behaviour therapy, and education for caregivers and family members.

Whilst VC underwent a period of assessment and treatment with medication, he chose not to access psychological assessment or interventions that are prescribed in NICE guidance. During VC's inpatient admissions his wishes to engage minimally with interventions were acknowledged and respected over any considered need for VC to engage with interventions to support his recovery. This would go on to be a theme throughout VC's care and treatment with mental health services, both as an inpatient and in the community.

VC's family told the independent investigation that they had not been told that VC's diagnosis was paranoid schizophrenia, and they believe that VC was under the impression that his diagnosis was psychosis. While there is evidence in VC's clinical record that his diagnosis was, at times, discussed with him, the family believe that he was not well at that time, and this would have impacted his capacity to understand and recall these conversations. VC's family told the independent investigation that they would have felt better equipped to have supported VC with his mental health if they had been aware that he was experiencing an enduring condition (schizophrenia) rather than a fleeting, episodic condition.

NICE guidance Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE states 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. 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.
• Role of teams and services.
• Getting help in a crisis.

The NICE guidance goes on to state that family intervention should:

- include the person with psychosis or schizophrenia if practical

- be carried out for between 3 months and 1 year
- include at least 10 planned sessions
- take account of the whole family's preference for either single-family intervention or multi-family group intervention
- take account of the relationship between the main carer and the person with psychosis or schizophrenia
- have a specific supportive, educational or treatment function and include negotiated problem solving or crisis management work

Between the first mention of schizophrenia (July 2020) and VC withdrawing his consent for staff to engage with VC's family (December 2021) there was a period in which there was the opportunity to provide the family education in line with NICE guidance. Even after consent had been withdrawn, this would not have prohibited family education.

The responsible consultant during VC's fourth admission discussed VC's diagnosis with the independent investigation. He said:

> "I think by then….I was coming to a conclusion that we're dealing with someone who's quite early in the journey in terms of mental illness, because the very first episode was in 2020. It was in the context of acute stress. The diagnosis in 2020 was schizophrenia. I didn't have notes from the private hospital, but there was a discharge summary which was copied and pasted onto RiO ... So there was actually slightly conflicting information throughout in terms of… the diagnosis of schizophrenia was not running throughout actually. So the initial impression was more around acute psychotic. So that was from [Consultant 1] who happened to just reassess him within two weeks of the first admission, for his first discharge and put him on a Section 3. That's when the diagnosis of schizophrenia was made, but he only stayed on the ward for two or three weeks on Section 3 in 2020.'
>
> 'The further admission to [independent provider 1] in 2021…they discharged him with a diagnosis of psychosis. I don't think they used psychosis… but they

said psychotic illness. He got actually transferred from PICU to a private open unit. They discharged him within two weeks, two or three weeks, I think, with a diagnosis of schizophrenia.'

'The Section 3 paper from the year before also did not mention schizophrenia, but just said psychotic illness, and the most recent Mental Health Act paper also mentioned psychotic illness and the community team all along, well most of them at least, said first episode psychosis. The picture wasn't very clear that this is schizophrenia, although in my opinion, it was heading towards schizophrenia, but at that time, there were… several pointers which made me wonder, "Are we dealing with more of an acute and transient psychotic illness, rather than a well-established clear-cut schizophrenia?" because every episode he had was very much acute in onset, within a matter of days.'

Comment

The independent investigation acknowledges that the terms psychosis and schizophrenia can often be used interchangeably by clinicians. In VC's case psychosis was one of the symptoms of his mental health condition, schizophrenia. However, there was some queries amongst treating clinicians about whether this was an episodic psychotic illness or schizophrenia.

Whilst treatment is largely the same, VC's family consider that having knowledge that VC had a severe and enduring mental health condition would have been beneficial to them and the way in which they understood and were able to support VC. They did not receive any education about VC's diagnosis which they would have found beneficial.

7.4.12 Medication

VC was prescribed three different antipsychotic medications during his engagement with mental health services (May 2020 to September 2022). He was documented as being non-concordant with his medication when in the community from early in his engagement with mental health services. His second admission was preceded by a period of at least two weeks without taking his medication.

Whilst an inpatient, VC was concordant with medication and appeared to recover quickly. Depot medication (slow-release medication via injection) was discussed amongst the clinical team and with VC for the first time during his second inpatient admission (whilst he was on a Section 3) as it was recognised that he had not been consistently taking his medication following his last discharge from hospital. The notes state that VC 'takes medication while on the ward but then stops once discharged. [Consultant 1] explained pros and cons of depot. [VC] will think about it – ward staff to provide information. Also, brief discussion about mechanisms of action of antipsychotics.' It is documented that later that day VC was given information regarding the aripiprazole depot.

Five days later, VC's mother queried about starting VC on a depot. The notes state that VC said, 'that he does not think he needs to make that decision now.' The treating Consultant 'stressed to [VC's] mother that staying in hospital won't make a difference to VC whilst he is well. The important thing is that he continues to take his medication on discharge.' The notes from that day also state that VC was informed by the treating Consultant that 'he has time to think about whether he wants to take a depot on discharge or would prefer to stay on oral tablets (ensuring his concordance).' VC's family felt that VC had become used to living with his symptoms and managed to appear "normal" most of the time, to the extent that they believe he managed to convince clinicians that he was coping when family had raised concerns.

VC's family also expressed concerns that VC was given autonomy to decide whether he wanted depot medication yet concerns about capacity had been raised and he had previously demonstrated non-concordance with medication.

Upon discharge, the notes suggest that the clinical team considered that VC had greater insight into his illness and that he understood the importance of medication and therefore considered this was sufficient justification to discharge VC with oral medication.

A discussion regarding possible use of depot medication took place by phone between VC and Care Coordinator 1 on 17 September 2021, during his third admission to hospital. At this point VC had been an inpatient on a PICU at the out of area independent provider for two weeks and was under a Section 3. It is documented in the clinical notes that Care Coordinator 1 ‘discussed possibility of depot medication as one option, [VC] said that this would depend on the side effects however stated that it might be easier than taking medication everyday’.

On the same day, Care Coordinator 1 received an email from the PICU where VC was being cared for. The email said that VC: ‘is currently settled, at present he is concordant with his prescribed medication and as far as I am aware there are no plans to commence a depot. I think this would be best discussed when he is stepped down from a PICU and consideration is being given to what his needs will be in the community. He has remained generally low profile whilst being on the ward and his insight remains poor at this time.’

Care Coordinator 1 phoned VC that day and discussed possibility of depot medication as one option. VC said that this would depend on the side effects. However, he stated that it might be easier than taking medication every day.

Less than two weeks later, VC was transferred to another independent provider whilst still under Section 3 of the MHA. Care Coordinator 1 attended a virtual ward round on 14 October 2021 and subsequently documented: ‘they do not feel that [VC] will need to stay on a Section 3 and are actively planning discharge. Want him to sort his accommodation before he leaves hospital, [VC] has tentatively agreed to stay informally if Section 3 is rescinded although said he would rather not wait’. Just over

a week later, VC was discharged back to the community to engage voluntarily with the EIP team and was prescribed oral antipsychotic medication.

When the MHA assessment was undertaken which led to VC's fourth admission, the treating Consultant documented 'I explained to [VC] I felt concerned enough to suggest hospital admission for further assessment, and to look at starting depot antipsychotic. I suggested a 14-day admission, which he refused.' He was subsequently admitted on a Section 2 of the MHA and the doctor documented the following plan:

> '1. Detain under section II
> 2. Will need full clerking, physical, bloods, and ECG
> 3. Careful assessment of the potential risk to staff will be required over the initial part of the admission - though his initial reaction appeared more frustrated than dangerous.
> 4. I would suggest continuing aripiprazole 20mg od for now and explore depot prior to discharge.'

During an MDT that took place on 31 January 2022 it is documented that VC 'doesn't wish to have depot and has been concordant with current medication. We need to gain further details about his mental health history from CPN and collateral to justify depot.'

Care Coordinator 1 attended the ward round on 3 February 2022. It is documented that they explained that they were not sure whether VC is concordant with medication, and he had not been collecting medication on time, and they felt that he would be better off on a depot. It was noted that VC had refused depot medication when the treating Consultant discussed it with him earlier in the week. At the next ward review on 10 February 2022, Care Coordinator 1 said that they wished VC had the depot during his last admission due to risk of non-concordance with medication. Care Coordinator 1 'emphasised that there were multiple times in the past that he

didn’t attend appointments with his consultant and expressed her opinions that a depot would be beneficial in the long term.’

The responsible consultant during VC’s fourth admission told the independent investigation:

> “I spent quite some time discussing with him about depot actually, going through the pros and cons, etc. He was adamant that he didn’t want to take depot and he was, again, insistent that he would continue to take the old medications and he didn’t have any problem with that and he would continue to work with the EIP team. So that’s the impression I had of him at the time.”

The treating Consultant documented that he explained to VC that they wanted reassurance that he would engage with Care Coordinator 1 and their team upon discharge. It was explained that they had a duty of care to give him the right treatment and that they would have to consider the depot if he does not engage with the team. It was subsequently documented in the plan that depot should be considered if he relapsed again.

During a further ward round on 17 February 2022, it was documented that it ‘was explained that the community team thought that a depot form of medication would be beneficial. VC said that he would not like to be on a depot.’

Finding

VC's concordance with medication was in question shortly after each discharge from hospital. Sometimes his partial concordance was explained away by his misunderstanding of the number of tablets to take at a time and by forgetting to collect his medication. Even when under close observation by the Crisis team in January 2022, they experienced difficulty in determining his medication concordance.

On each hospital admission there was an opportunity to consider putting in place arrangements for depot medication. This was not agreed to by VC and the decision was made not to administer depot medication. By the time VC was on his fourth admission there was a pattern of concordance in hospital and non-concordance in the community with his medication and with his willingness to engage with his clinical team.

During his admissions under Section 3 of the MHA, there was the option to discharge VC under a community treatment order (CTO). A CTO can incorporate conditions, including a condition to comply with depot medication, with the option of recall to hospital if non-compliant. This provides a level of compulsion in the community that is otherwise not possible. The EIP team were seeking this intervention for VC to support his engagement when he was disengaging from services. A CTO could have also provided VC with the opportunity to explore how he felt when he was appropriately medicated.

The inpatient teams involved in VC's care were trying to treat VC in the least restrictive way and took on board VC's reasons for not wanting to take depot medication which included him not liking needles. His wishes were balanced against the fact that he was judged to have capacity and taking his medication on the ward which assured the team he was willing to take his medication in the community and work with the community team. On the fourth admission he was not displaying active symptoms of psychosis and the clinical team considered that they could not justify a move to a Section 3 of the MHA at that time. The early use of a CTO provides the opportunity to recall an individual to hospital in the event of a deterioration in the community under the CTO provisions within the MHA.

Finding

A theme running through VC's clinical records is that he did not consider himself to have a mental health condition. His insight into his condition did not appear to increase and therefore his understanding of the importance of medication in his case never appeared to be understood. Whilst he may have clinically improved during his inpatient stays, he did not demonstrate retrospective insight, this is an important factor to consider when looking for an understanding of mental health.

Capacity

Mental capacity refers to the ability to use and understand information to make a particular decision, and communicate any decision made. A person lacks capacity if their mind is impaired or disturbed in some way, which means they are unable to make a decision at that time.

The Mental Health Act Code of Practice states that "a person is 'unable to make a decision' for themselves if they are unable to do any one of the following:

- Understand information which is relevant to the decision to be made
- Retain that information in their mind
- Use or weigh that information as part of the decision-making process, or
- communicate their decision (whether by talking, sign language or any other means)."

Under the Mental Capacity Act (2005), it must be assumed that a person has the capacity to make decisions, unless it is proven otherwise. Where there are concerns, a capacity assessment should be carried out. Assessing capacity under the Mental Capacity Act (2005) in mental health services involves an assessment of the person's ability to use and understand information to make a decision, and to communicate any decision made.

In VC's case, there were a number of occasions when VC's capacity to consent to treatment and to make decisions was considered. These considerations of capacity primarily occurred when VC was being assessed in hospital for detention under the MHA.

During VC's second MHA assessment (which led to his first detention under the MHA) it is documented that VC's 'Insight was limited and he lacked capacity to consent for treatment', and that he did not have capacity to consent to admission. He was therefore sectioned under section 2 of the MHA. Four days later he was documented as having capacity. Under a ward round on 2 June 2020, it is documented that VC 'understands the information relevant to making a decision about admission and treatment, can retain this long enough to weigh up pros and cons of different decision and is able to communicate his decision.'

When VC was admitted for a second time, the 72-hour review completed on 16 July 2020 stated; 'on the balance of probabilities and existing capacity guidance, this person DOES NOT have the capacity to make decisions about admission and or treatment.' This is documented as the assessment again on 21 July 2020. By 25 July 2020 VC was documented to have capacity. However, VC's ward round assessment on 28 July 2020 reverts back to considering that VC does not have capacity and states that he does not accept that he has a mental illness.

During the assessment for VC's fourth admission, it is documented that it 'appears that he does not have the capacity to make a decision in regard to his ongoing assessment and treatment.'

Whilst VC, at times, he was not considered to have capacity to make decisions in relation to his treatment, in the same assessments, conversations are documented about treatment options such as depot injections. VC's wishes not to receive his medication via injection are respected, yet earlier in the assessment it says that he lacks insight and does not consider that he has a mental health condition.

Where a mental health patient lacks capacity to make decisions regarding their treatment, the treatment should either be given in accordance with an assessment of their best interests under the Mental Capacity Act (which will include their wishes and feelings although these may not be determinative of the issue) or under the powers of compulsion provided by the MHA. The MHA provides powers of compulsion in hospital when the patient is detained under a relevant section (including sections 2 and 3) or in the community under a CTO.

Comment

Capacity is a dynamic phenomenon, a person can have capacity to make one type of decision but lack it to make another (perhaps more in-depth) decision. It can also fluctuate depending on how their mental disorder is affecting them at any given time.

There is nothing in the clinical records to suggest that, whilst under the care of the community mental health teams, there was a consistent approach to assessing VC's capacity which subsequently informed VC's treatment plan. VC's care under the EIP team in the community was on a voluntary basis and his decision to engage or not engage with certain activities were viewed through the lens that he had capacity to make those informed decisions. However, throughout VC's engagement with mental health services he demonstrated little insight into his mental health condition and often denied that his symptoms were a result of his mental health. This lack of acceptance of his condition was most likely a symptom of his psychosis. This could potentially impact his ability to understand and weigh up the information presented to him about medication and treatment options and the associated risks with non-concordance.

Engagement with the EIP team on a voluntary basis makes the assumption that VC's capacity remained static from his previous assessment, when an inpatient and he therefore had the capacity to make informed decisions about his care and treatment during his interaction with the community team. The Trust's EIP policy does not make reference to the need to fully ensure individuals are making informed decisions

about their care and treatment with capacity. The Trust's CPA policy states that 'risk to self and others should always be assessed in the context of a service user's capacity to make an informed choice about the risks they are taking. It could be argued that VC's risks (in the context of non-concordance with medication and disengagement) could not be viewed as an informed choice because of his lack of insight into his illness.

Shared decision making, where capacity has been judged as present, and least restrictive practice is intended to be balanced with recognised risks. Achieving this balance relies upon clinical judgment with best practice suggesting collaboration across staff, carers and families.

VC's family consider that his mental state made it difficult for him to retain information, particularly regarding his diagnosis. They also question how when he could be deemed to not have capacity, that his wishes to not include them in his care planning, could be taken on board.

Comment

Patients with chronic psychotic symptoms (as it is likely VC had) can struggle with both the 'understanding' and in particular the 'weighing up' arms of the capacity assessment. Delusional beliefs can be strong and outweigh more rational explanations when weighing up information to make a decision.

Finding

VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement, particularly in the community. There does not appear to be a systemised approach to assessing patient capacity based on presentations across care settings and relied upon in the context of voluntary treatment within the community. Therefore, the question of capacity does not appear to inform all assessments of risk across the different care settings.

7.4.13 Use of sections under the Mental Health Act and consideration of a Community Treatment Order

VC was admitted to hospital on four occasions following assessment and detention under the MHA. On three occasions VC was admitted under Section 2 (for assessment) and on one occasion he was admitted under Section 3 (for treatment of a known disorder). On the third admission, the Section 2 was converted to a Section 3.

A Section 2 allows for a period of up to 28 days for assessment and treatment and a Section 3 allows for an initial treatment period of up to six months. The length of VC's admissions ranged between 17 and 48 days. The national average length of stay in 2023 for an acute mental health inpatient bed was 39 days. Although a variety of factors may affect the length of stay, including the nature of the patient's diagnosis. Mental Health 360 | Acute Care For Adults | The King's Fund (kingsfund.org.uk)

During VC's third hospital admission (to an out of area independent provider) he was initially placed on a Section 2, but this was converted to a Section 3 during his stay on the PICU. He remained on a Section 3 when his care was stepped-down to another out of area independent provider 10 days later. Interviewees described this as a potential opportunity for VC to be considered for a Community Treatment Order (CTO).

A CTO allows a person who has been detained in hospital for treatment to leave hospital (discharged from inpatient detention) and receive treatment in the community. It is intended to support the risk associated with issues such as non-engagement If an individual does not follow the conditions set out in the CTO (for example receiving medication by depot injection) they can be recalled to hospital and detained for treatment.

The purpose of CTO is to allow patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and harm to the patient or to others.

Only patients who are detained in hospital for treatment under section 3 of the MHA, or certain forensic sections where they have been diverted by criminal justice system, can be considered for a CTO Purpose of SCT (shsc.nhs.uk). It is therefore the clinicians within the inpatient setting who will determine whether more restrictive practice in the community setting should be applied at the point of discharge. Patients detained in hospital for assessment under section 2 of the Act are not eligible. CTO is an option only for patients who meet all the following criteria:

1. The patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment;
2. It is necessary for the patient's health or safety or for the protection of others that the patient should receive such treatment;
3. Subject to the patient being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital;
4. It is necessary that the Responsible Clinician (RC) should be able to exercise the power to recall the patient to hospital; and
5. Appropriate medical treatment is available for the patient

VC met the above criteria to be considered for a CTO. However, inpatient staff told the independent investigation that it would have been difficult to introduce a CTO because VC was concordant on the ward and not showing signs of needing his treatment to be enforced. Additionally, evidence suggests that inpatient teams repeatedly took account of VC's wishes not to pursue the use of depot medication, as he feared the impact on his studies. At the point of each discharge, there was nothing in the clinical records to suggest that VC lacked capacity. Therefore, a CTO was not assessed as required as it was considered that VC understood the need for treatment and he provided reassurance around his willingness to be concordant with medication and to engage with the community team.

An inpatient consultant told the independent investigation:

> "…clinically, we didn't have any ongoing concerns in terms of his presentation, but in terms of the risk management plan, he was open to EIP team. He had a care coordinator. He had a community consultant. He was open to the university Student Support Service, and the EIP team generally do good case management with regular follow-ups, etc. So that kind of reassured me at that point that there was a plan that could work for him."

However, the EIP team were feeding into inpatient wards rounds regularly that they had concerns about VC's concordance with medication and engagement with the team when in the community. Their concerns were documented in the clinical records and shared with the independent investigation during interviews. A member of the EIP told the investigation that they considered the third admission (with the independent provider) to be a key opportunity to place VC on a CTO with a requirement for depot medication:

> "…they [inpatient staff] might say it was difficult for them to argue that he would necessarily reach the threshold for a [section] three and then a CTO and a depot at that point [admission 3].,,Because in the assessment bit I don't remember there was much there…But, yeah, that was very different to the previous admission, I think that would have been probably the best opportunity to argue the case for maybe a CTO and a depot but he didn't want to depot…"

Comment

In VC's third admission, from the point of VC being so acutely unwell that he required being held in seclusion for nine days, through to discharge back into the community for voluntary engagement with EIP was 48 days. This is a short time to try to reach a shared understanding with VC about his diagnosis and future management. Although it could have been viewed longitudinally as part of a pattern of relapse following non-compliance in the community.

A community psychiatrist told the independent investigation about a conversation they had with a ward psychiatrist during VC's fourth hospital admission:

> "I made it very clear that we had found it almost impossible to reach him [VC] in the last three months, that he had missed numerous appointments, he'd given us false addresses, that actually, unless there was something different, potentially a depot and a CTO in place, I didn't feel that we really stood a chance once he was discharged. And I was very concerned.

The community psychiatrist did acknowledge the difficult position the ward staff faced during VC's fourth admission given VC's presentation:

> "[They] didn't feel he was very unwell, that, you know, the psychosis wasn't forthcoming during that final admission. It was difficult for him to convert from the Section 2 to a Section 3. There just didn't seem to be grounds, and I think that made it quite hard."

An inpatient consultant told the independent investigation that it would be for the community team to request consideration of a CTO. The clinical records document that the community team did make this request on numerous occasions, particularly during VC's third and fourth hospital admission. However, during VC's fourth hospital admission, four days before discharge, VC was taken off section and remained in hospital as an informal patient while his accommodation was arranged. It was considered by the inpatient clinical team that upon adjustment of VC's medication to

something “more tolerable” that he had been suitably stabilised to hand over to the community team with a safe care package.

The disconnect between his hospital presentation and his community presentation is described by a community psychiatrist to the independent investigation:

> “…Once he's an inpatient... Because he presents as very low profile, very amenable, and keeps himself to himself, there often isn't a real florid psychotic presentation. This is PICU aside. I'm thinking more of the acute inpatient setting. He's probably just not very prominent, and it's just not maybe felt that a more restrictive approach is necessary, and perhaps there's no thought about what he's like in the community, which is very different.”

Guidance published by NHS England in July 2024 entitled: Guidance to integrated care boards on intensive and assertive community mental health care says that in cases where there is a history of poor engagement, consideration should be given to the use of supervised treatment within the framework of a community treatment order for eligible individuals (usually those subject to section 3). NHS England » Guidance to integrated care boards on intensive and assertive community mental health care

It goes on to say that there may be shared factors which may be of relevance in deciding whether to use a CTO. Whilst this guidance has been produced with the benefit of hindsight, since the tragic events in June 2023, the principles of what constitutes consideration for a CTO have not changed.

Factor	Present in VC's case
Presence of severe mental illness including psychotic presentations, in which an individual shows a poor awareness of their illness (including the need for treatment and their risks associated with relapse)	√
Evidence of previous positive response to treatment	√
Previous poor compliance with the treatment plan (including discontinuation of medication)	√
Previous hospital detentions due to the risks they pose during relapse to their own health and safety and to others	√
Disorganised behaviour/avoidance of contact resulting in being lost to follow up	√
Unsuccessful prior attempts to engage the individual with a less restrictive approach	√

The independent investigation heard from interviewees about the need to act in a least restrictive way as possible. The independent investigation heard that one of the ethos's of EIP is that it is a patient centred, patient-focused service based on a recovery model of care. Particularly early on in someone's treatment, there is a real emphasis to try to collaborate with them. Interviewees told the independent investigation that they try not to have an extremely restrictive approach unless absolutely necessary. Examples were given of university students who develop psychosis for the first time and the efforts that are taken by the team to work as closely as possible with them in as creative a way as they can to support engagement and recovery.

A community psychiatrist told the independent investigation:

> "He [VC] made it very clear that he didn't really want the team interfering too much, that he would engage with us, but it was very much on his terms. So we had to try and be a bit creative because what I didn't want was to completely alienate him at that point. I hadn't managed to see him at all in the previous three months. So just being able to keep eyes on him was better than not seeing him at all and him totally being disengaged from his CPN. You almost have to try and weigh things up and strike a bit of a balance. And it was really hard. So he did come, he did collect his medication. He didn't really engage in a particularly meaningful way, between March and July [2022]. But at least we believe he was picking up his medication. As to whether or not he was taking it, it was difficult to be completely certain because he wasn't on a depot. That would have perhaps given us a bit more clarity. And then sadly, again, he disengaged, and so we just had a whole year of very… almost impossible to engage. It felt quite hopeless if I'm honest."

Comment

Restricting someone's liberty is not a decision that should be made without strong evidence to suggest that it is in the best interests of the individual and/or others. However, the lack of visibility, due to non-engagement, of the hazards posed through an established pattern of deterioration in mental health which can lead to acts of violence, could suggest a need for greater levels of restrictive practice in certain circumstances.

Within the EIP services there is also a question as to what other options were available to try to engage VC. EIP staff during interview, described a desire to move him to depot medication but there was the potential of other options on a spectrum – at one end the antipsychotic medication he was taking and at the far end, depot injections. For example, other medications could have been considered along with the therapies and interventions described in the NICE guidelines such as peer support and family therapy. Additionally, there is nothing to suggest that at any point a conversation took place between VC and

the clinical team whereby the team conveyed that they would try to take the least restrictive approach, e.g. no depot and voluntary engagement. However, having a clear plan in place, understood by VC, that if that approach did not work, demonstrated by non-concordance with medication or not attending appointments, then they would need to take a different approach. This may be an inpatient admission to better understand him and try different treatment options or consideration on the best route to ensure concordance with medication through a depot injection. VC was essentially treated in a recovery focused model of care but without being given the menu of options to aid his recovery.

The notes suggest an absence of clear conversations with VC about risk and what that means for the routes to take to keep him and others safe.

The investigation heard evidence that clinicians were influenced by the comments within the Draft Mental Health Bill (2022), relating to the desire for a reduction in use of CTOs and its disproportionate use for black people. The investigation findings also reflect the tension described within the CQC (2022) report between families' beliefs in the value of CTOs and challenges around their use as perceived overly restrictive by clinicians and patients.

As part of the Trust's internal serious incident investigation (SI), the panel considered whether the team involved in VC's fourth admission felt a pressure to avoid restrictive practice because of VC's ethnicity given the publicity surrounding the overuse of the mental health act and restrictive measures with black African and black Caribbean patients. The inpatient consultant acknowledged to the SI panel that staff were acutely conscious of the link between the MHA and restrictive practice, particularly in light of the reform of the Mental Health Act which was publicised around the time of VC's admission to the ward. Despite this awareness, the consultant was confident that this did not influence his decision making in relation to the use of a Section 3, a CTO or depo medication.

www.gov.uk/government/consultations/reforming-the-mental-health-act/reforming-the-mental-health-act

Comment

Whilst Trust staff reported that they considered race in relation to the use of restrictive practice, there is nothing in the notes to suggest that this important factor was discussed as an MDT. Such a discussion enables clinicians involved to have an open conversation to help to ensure that their decision-making is based on clinical presentation and need and is not influenced by other factors.

A Trust executive told the independent investigation:

> "I think, also, people would be thinking about the over-representation of young Black men under the Mental Health Act … So I'm sure that they were considering it. Personally, I think that there is a need to treat people as well…when people are experiencing symptoms of mental health- Particularly when I think about [VC] and his risk escalating and the damage it was doing to him, although most probably he wasn't able to always articulate that, you do have to balance that, don't you? I think that if you can justify that you've tried everything else which is least restrictive but still you are not able to minimise the risk or to minimise the symptomology, which was so distressing, then personally I think that actually depot medication could be enabling, not restrictive, if it allows somebody to maybe carry on with their life a bit. I do think it's something that you really, really, have to consider because it's not easy for a young person to be having depot medication or even to consider a CTO."

The independent investigation has also considered whether there was an opportunity to detain VC under a Section 3 on his fourth admission to hospital as opposed to a Section 2. The independent investigation acknowledges the need for clinicians to be as least restrictive in their practice as possible and that placing limitations on somebody's liberty is not a decision that should be taken lightly. However, by the

fourth admission there was a pattern emerging that VC very quickly disengaged from services once in the community and became non-concordant with medication. The risks associated with recognised hazards had not been fully explored, documented or mitigated against. Another hazard was VC's lack of insight into the fact that his symptoms were caused by his mental health condition. To add to this picture, VC appeared to recover quickly when an inpatient which could be argued that he therefore responded well to structured intervention and a period of structure within the community may have been of benefit.

It is acknowledged that clinicians use their autonomy to make decisions based on expert knowledge. There was a building history and recognised pattern to VC's presentation which was being described to the inpatient team by VC's family and Care Coordinator 1. In addition, he had previously had periods of assessment under Section 2 of the MHA and had a diagnosis of schizophrenia but what had not been achieved was a successful longer-term management plan for VC to support engagement and medication concordance following discharge from hospital. His presentation and diagnosis at that time deemed him suitable to be detained for treatment and for the health and safety of him and others. At this point, it was unclear what was to be achieved by a further period of assessment as opposed to treatment which would have been more in keeping with the fundamentals of the MHA as set-out in the Code of Practice. A longer inpatient episode at this point may have provided the opportunity to better understand what was happening for VC. Also, it would have given the opportunity to develop a shared understanding with VC about his symptoms, diagnosis and the plan for keeping him well. There would have also been the opportunity to really explore VC's experience of hearing voices as there is nothing in the notes to suggest a real examination of this.

There appeared to be an assumption made about VC's recovery when an inpatient, that an absence of hearing voices demonstrated recovery. However, there is nothing documented in the records which details what recovery looked like in VC's case for health professionals, VC or his family.

Finding

The investigation team consider that whilst decisions made were thought to be appropriate by those involved at the point at which they were made. The piece that appears to be missing is shared decision making across all teams involved in VC's care. The community team fed into discussions about VC's care and their concerns about his non-concordance in the community. However, ultimately the decision appears to lie with the inpatient consultant as the Responsible Clinician. There are complexities with the Responsible Clinician having to make a clinical decision when the individual's presentation contradicts what is being reported from a longitudinal perspective.

The way that the system is configured, the emphasis is placed on the inpatient Responsible Clinician to make discharge decisions. If the system required inpatient and community consultants to have shared responsibility and joint decision making, then the autonomy of a single clinician (Responsible Clinician) might avoid the dominance of a perspective based on observations from one clinical setting.

The guidance states that, if the individual has a care coordinator in the community, then they should be involved in any discharge planning. Guidance also suggests that families or carers should also be involved in discharge planning. However, interviews from this investigation suggest that ultimately the Responsible Clinician makes the discharge decision. There is therefore a bigger question about why the culture appears to promote an individual in a specific role making the decisions even if this is at odds with the guidance and views of others involved in an individual's care.

7.4.14 Assertive outreach

Assertive Outreach involves taking services to the patients rather than requiring them to attend hospitals and clinics. The model is one of a high staff-to-patient ratio offering comprehensive health and social care support. Research evidence and outcome data suggests it results in reduced hospitalisations, promotes effective engagement with difficult to engage patients and improves patient wellbeing. Assertive Outreach in Mental Health: A manual for practitioners | Oxford Academic (oup.com)

The assertive outreach model of care became embedded in the early 2000s when the National Health Service Plan identified assertive outreach as a necessary component of community mental health provision (Department of Health, 2000). This resulted in the rapid introduction of discrete assertive community treatment teams in the UK. This was at a time when the care and treatment of mental health had escalated in priority for a number of reasons, one of which was following the Christopher Clunis case which raised concerns about public safety the-christopher-clunis-enquiry.pdf (cambridge.org).

There were various models of assertive outreach across the country until the 2010s when research for Community Care revealed that, between 2010 and 2015, mental health funding was reduced by 8.25%, with community teams overall losing 5% of their budgets while referrals increased by 20%. A further 2,100 inpatient beds were closed. At the same time, local authority spending on working age adults with mental health needs fell by 13.2% in real terms (McNicoll 2015). Assertive outreach teams lost 56% of their budgets.

This time coincided with a move away from centralised targets and a move back towards local decision making. With the reduction in budgets, many Trusts combined the function of assertive outreach within the local mental health team, and it became part of the role of the care coordinator to assertively outreach to those on their caseload. However, with reduced staff, higher caseloads and an increased acuity of illness amongst the caseload (due to fewer inpatient beds and high demand of the

Crisis service), experts spoken to as part of this investigation questioned if the assertive outreach function has been delivered as imagined. Additionally, we heard that part of the demise was due to the lack of research evidence and a growing body of people who considered that it was not always therapeutic. Experts by lived experience told the independent investigation that some people felt it was more of a monitoring service.

Historically, assertive outreach services would have provided the opportunity to bridge a gap when service users are not willing or able to engage with services but who are not subject to restrictions under the MHA. There appears to be little evidence that there is currently a widely used dedicated assertive outreach model of care as defined by the research literature.

The Trust's EIP Service Operational Policy (undated but in use at the time) states that 'all efforts will be made to ensure that a service user engages with the service when a first episode psychosis is suspected.' The policy says that staff will work with service users through an 'assertive approach to care, multidisciplinary team discussions, supervision and risk management, the team will adopt a creative response when it is difficult to establish engagement.' It also states that a clearly documented plan to support the service user's non-engagement will be developed.

From interviews with Trust staff, it is apparent that the current workload and model of care delivery makes assertive outreach in its intended format, difficult to achieve. The policy is disconnected with the reality of what is possible to deliver within the constraints of service budget and resources.

NHS England recognises that this has potentially become a national issue and on 26 July 2024, NHS England issued guidance on intensive and assertive community mental health treatment. Within the guidance document it states 'As a first step in improving care, NHS England included a requirement in the 2024/25 NHS Priorities and Operational Planning Guidance that all ICBs "review their community services by Q2 2024/25 to ensure that they have clear policies and practice in place for

patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge".' The guidance also states 'Systems have a responsibility to ensure they commission the right mix of services to support the needs of their local populations. This includes a dedicated resource to provide intensive and assertive care for those individuals who need it.' NHS England » Guidance to integrated care boards on intensive and assertive community mental health care

Comment

It is important to recognise that the assertive approach the EIP were able to offer was constrained by resources and did not reflect the policy. However, even if the service was able to spend time and resources trying to reach out to VC in a more intensive way, it does not mean that he would have engaged. In fact, this may have had the opposite effect given the paranoid thoughts he was often experiencing. What would have been more beneficial was to develop a shared understanding with VC about what services might interest him and help him to engage with treatment and remain curious about his mental health. With VC having the ability to choose from the menu of offers of what EIP should be providing as part of treatment and recovery. Assertive outreach would then be available as more of a monitoring and support mechanism if the first approach was unsuccessful.

Finding

NHS England's recent review and guidance indicates that assertive outreach should be a discrete resource but recognises while some ICBs may already commission 'assertive outreach' teams or similar, others may not currently commission a specific team or service focused on intensive and assertive approaches. This aligns to the information and evidence provided to the independent investigation, that suggested that the majority of dedicated assertive outreach teams as a standalone function were disbanded over 10 years ago. Alternative models for supporting service users who do not choose to, or are unable to engage with mental health services have developed. However, there is variation in the approach, dedicated protected resources and in outcomes for patients. VC's clinical records and interviews with community Trust staff do, to an extent, demonstrate an element of an assertive approach. However, this was constrained by the service model and workload within the team.

Out of area placements

An out of area placement (OAP) is a bed in a unit that does not form part of the usual local network of service providers. It is used when a person who has been assessed as having an acute mental health need required an inpatient bed but, for a number of reasons, one is not able to be provided within the local network.

The government set a national ambition to eliminate inappropriate out of OAPs in mental health services for adults in acute inpatient care by 2020 to 2021 Out of area placements in mental health services for adults in acute inpatient care - GOV.UK (www.gov.uk) The rationale to move away from OAP is that model of care does not allow for the individual to be visited regularly by their care coordinator to ensure continuity of care and to support effective discharge planning. Being treated in their local area, it enables individuals to retain the contact they want to maintain with family, carers and friends, and to feel as familiar as possible with the local environment.

However, it is widely recognised that achieving zero use of OAPs has largely been unachievable across the country. The Trust caring for VC confirmed that they have been unable to eliminate the use of OAP – both in terms of 'spot-purchased' beds and 'sub-contracted' beds. Spot-purchased beds are a one-off purchase made to meet a specific demand. Sub-contracted beds are where the Trust has a contract with a specific provider who can take their patients. For example, the investigation heard at one point, the Trust had a subcontract with an independent provider who would, at any one time, have a whole ward of the Trust's patients.

An interviewee told the independent investigation that the aspiration is not to use spot-purchased provision and be able to rely on the subcontract and Trust beds. They said that having oversight and assurance is far harder to achieve with spot-purchased providers as they can be anywhere in the country, and you may not use them frequently enough to build up a picture of the quality of the service.

> "I think with the spot-purchase because they're often, as I say, in very distant parts of the country you're very much more reliant on, either the clinical team or the family telling you about concerns that they have or the provider, on their own initiative, actually raising concerns themselves so that we're aware of them. Or the patient, of course. So there's less of an ability to triangulate that information, just because of the nature of the subcontract. We're not consistently using one spot-purchased provider."

The Trust reported 'inappropriate out of area bed use' to be 106.7% for the years of 2022/2023. This meant that they were operating at 6.7% above their bed capacity. This demonstrates an increase in out of area bed use over the years. The implications of increased use of independent providers compounded existing challenges managed by community staff. These included a lack interoperability of technical communication systems between NHS and independent providers. Staff also reflected to the investigation there were known challenges in ensuring community staff were included at the multidisciplinary team meetings and discharge planning for patients from independent providers.

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It was documented in VC's clinical records that, when he was considered to be experiencing a deterioration in his mental health shortly before his third admission, he was referred for a MHA assessment and was placed on the bed waiting list. It was documented that VC was not to be sent to an out of area bed as VC and his family had declined this.

Whilst the change of plan is not recorded in VC's clinical records, Trust staff told the independent investigation that the reason VC was placed out of area was because he was assessed as needing a PICU bed and there was no local provision available. While awaiting a bed, VC was being cared for in seclusion on a 136 suite, it was recognised that he should not remain in the suite for any longer than necessary as it is not considered conducive to safe and effective care and treatment.

A PICU bed was therefore 'spot-purchased' for VC. A request for a PICU bed was made on 31 August 2021 and he was not accepted by a provider until 10 September 2021. Interviewees told the independent investigation that there may have been a number of factors contributing to the delay including the risk that VC was assessed to pose at that time and the potential need for seclusion when not all PICUs have access to seclusion areas.

After a couple of weeks, VC was considered to no longer require a PICU bed but still required inpatient treatment for step-down care. He was subsequently placed in a sub-contracted bed at another independent provider. It was not documented why he was placed in a sub-contracted bed rather than brought back to a Trust acute inpatient bed.

An interviewee told the independent investigation:

> "Ideally, my reflection would've been, "With the complexity this gentleman posed, and actually the three admissions in a very quick space of time, actually a repatriation back to a Trust bed that might have known him a little bit better might have been a more helpful pathway for him. That's a reflection with hindsight."

We asked staff what the benefits of keeping an individual in the Trust rather than using an OAP are. One interviewee told the independent investigation:

> "The benefits of somebody having some degree of relationship with an inpatient team are immeasurable, sometimes, in terms of their understanding of the risk and the process."

The independent investigation asked staff what information the independent provider can access regarding the patient they are caring for. They said that whilst the Trust can share vast amount of information with an independent provider and send information to support continuity of care, it relies on staff reviewing all the information and understanding the nuances. They said that this is far easier with a team who might have met the individual before and know a bit about them. Additionally, it is more likely that if an individual is admitted within the Trust, then clinicians are more likely to know the previous team and call them to discuss plans for care and treatment and gather more nuanced information.

The independent investigation learnt that the independent provider will generally, share information about an individual's stay on a weekly basis. This will include a summary on the technical system of anything that has been discussed and agreed during the ward round. On discharge, the independent provider will share with the Trust a summary of the stay, and a discharge summary including a risk assessment. They will also share the plan for medication and follow-up arrangements.

During VC's stay with the independent providers, care plans and risk documentation was completed.

A number of interviewees viewed VC's third hospital admission as the potential opportunity to place VC on a Section 3 and begin a Community Treatment Order. Such an order could have required that VC receive his medication through depot injection to ensure concordance, particularly given his escalated risk and level of violence used in the lead up to this admission.

A member of the EIP team told the independent investigation:

> "…By the third admission when he went in and then he went on a [Section] three I remember thinking, "Oh this might be the opportunity now to talk about a depot in more detail now he's on a three." But unfortunately, that didn't happen, and he went to a private hospital somewhere. And I think I remember asking them and they said they weren't considering it, and I think he was on a PICU at that point and then he ended up getting discharged quite quickly and we didn't even know he'd been discharged, so that opportunity had gone."

VC's family told the independent investigation that they were not included in the care planning for VC during his stay on the PICU or the acute ward. They said that they only learnt that VC had been discharged from hospital on 22 October 2021 when VC's mother called the ward for an update on VC's progress. The Trust notes suggest that VC's EIP care coordinator was also not informed of the discharge, although notes from the independent hospital provider described that Care Coordinator 1 was informed about his discharge.

Finding

Nationally, it is recognised that it is best to deliver care locally wherever possible and the aspiration is to not use spot-purchased out of area placements. In VC's case, the Trust had to send VC to a PICU bed and then an acute bed out of area due to a lack of local capacity. Whilst the records suggest that he received regular assessments and, where possible, Care Coordinator 1 attended ward rounds virtually, it is recognised nationally, that something is lost by not keeping care delivery local. In VC's case, these admissions came at an important point in the treatment of his mental illness, in that a pattern of his engagement as an inpatient versus non engagement in the community was forming. This may have been the opportunity to fully see the pattern and to take seriously the concerns of Care Coordinator 1 and consider using the time VC spent on a Section 3 to explore a Community Treatment Order.

7.4.15 Discharge from secondary mental health services back to GP

In complex, under resourced systems (arguably such as healthcare), positive work outcomes are often only achieved because of the adaptations of staff on the ground, that are implicitly tolerated by the organisation, but after an adverse event, are labelled as errors, substandard, or violations. The independent investigation has learnt that VC being discharged due to non-engagement was not a one-off drift from operational practice. Instead, there was a level of normalisation of this practice which was being tolerated by the service. The investigation's findings in this area is supported by a recent publication - Sailing Too Close to the Wind? How Harnessing Patient Voice Can Identify Drift towards Boundaries of Acceptable Performance Sailing too close to the wind? How harnessing patient voice can identify drift towards boundaries of acceptable performance — University of Strathclyde.

There have been recent publications regarding the need to ensure that discharges from mental health services are safe and patient-centred. In February 2024 the Parliamentary Health Service Ombudsman published a report Discharge from mental health care: making it safe and patient-centred | Parliamentary and Health Service Ombudsman (PHSO) which included case studies which resonate with VC's discharge in that family were not involved in the discharge process or consulted to help inform the view of risk.

The independent investigation considers that the final discharge from secondary mental health services was an opportunity to pause, consider and understand all the information held in relation to VC to make an informed risk-led decision.

Trust policy and procedure

The Trust's EIP Service Operational Policy (undated but in use at the time) states that 'all efforts will be made to ensure that a service user engages with the service when a first episode psychosis is suspected.' The policy says that staff will work with service users through an 'assertive approach to care, multidisciplinary team discussions, supervision and risk management, the team will adopt a creative

response when it is difficult to establish engagement.' It also states that a clearly documented plan to support the service user's non-engagement will be developed.

The Trust's 'Merged Do Not Attends (DNA's)/Cancellations & Management of Patients Who Fail to Engage with Services or Seek to Disengage from Care in an Unplanned Way Procedure' (September 2021) documents considerations and steps to be taken when a service user fails to engage. The procedure says: 'When it is clear a patient has not adhered to the agreed level of contact the Multidisciplinary Team (MDT) should undertake an immediate assessment of the patient's level of risk.'

VC's risk was not reassessed at any points of disengagement. However it could be said that there was not a clear point at which VC fully disengaged from services. From Spring 2022, he would occasionally answer his phone, reach out to Trust services or collect medication.

The procedure goes onto say 'the level of response by the team will be proportionate to the assessed level of risk of the patient.' VC's risk was often unknown when he was out of contact with services. It was therefore difficult to make a judgement on the appropriate level of response. Interviews with Trust staff demonstrated that staff did not consider VC to pose an immediate and serious risk to others and were therefore not acting in a way which was at odds with the level of risk they considered him to pose.

The procedure document states that if a patient is not contactable, a member of the team should call all recorded contacts to try to establish their whereabouts. These attempts should be recorded in the healthcare records and [the electronic recording system]. The procedure also says that if the patient is not at their registered address, then the team should agree other agencies to be contacted e.g. GP. This should include a discussion regarding contact with family members even if the patient has requested no family contact.

Despite VC withdrawing consent to speak with his family, Care Coordinator 2 did contact VC's mother on 31 August 2022 to try to establish his whereabouts. However, VC's mother had not seen him face to face for some time and did not know his location. A potential discharge from mental health services was not discussed during this call and at the point of discharge in September 2022, VC's family were not contacted. Staff cannot recall why this did not happen, but as discussed earlier in this report, the care coordinators were carrying high caseloads during this period which may have impacted their ability to carry out all expected tasks.

The procedural document goes on to say that: 'If all contacts fail the care co-ordinator should discuss their concerns with the MDT and agree the next steps to be taken. This may include involvement of the police.' EIP staff told the independent investigation that they considered reporting VC as a missing person but did not think this would be taken on. This was based on insights from previous engagements and that strictly speaking, he was not missing. However, at that time the courts had issued a warrant for VC's arrest on the same day that his discharge letter to the GP was sent.

Comment

The lack of visibility and sharing of this information across the system resulted in a discharge without a shared understanding between the EIP team and the other agencies involved.

The EIP DNA procedure document also documents that 'the care co-ordinator should undertake an assessment of the patient's capacity and appropriateness for discharge from the service.' However, it is not clear how this can be achieved when a patient is not engaging. During interviews, members of the EIP team expressed that they believed they had exhausted all options. An EIP worker told the independent investigation:

> "Well, it started breaking down, shall we say, I would say from May-June onwards. Everyone was… you know, this man was discussed probably at

every MDT. “Well, he did pick up his medication, but I didn't get a chance to talk to him. He didn't want to engage with me. So at least he's got his medication.” But even by that time, you know, I knew enough about this guy to know that he could throw it in the bin as soon as he walked out of there.”

During interviews, a number of the EIP team reflected on what other action could have been taken instead of discharging VC. An interviewee described this thought process to the independent investigation:

> “We considered CHRT, a Mental Health Act assessment, a missing person alert to the police, but it was really difficult because we just didn't have the evidence that VC was unwell or in crisis. We knew he wasn't engaging. We also knew through mum that he'd had some contact with family. He'd spoken to his sister on the phone. We knew that he'd requested his notes. But we had no evidence that he was unwell or in crisis.”

There was some consideration that as VC had not presented in the judicial system or come to the attention elsewhere, in an acutely unwell state, then he must not be unwell. One interviewee told the independent investigation:

> “That was something else that we’d considered. He’d not presented through custody. He’d not presented at the 136 Suite. So, there was an element where we thought, “Well, he’s not unwell.”

The independent investigation considers that there had been a normalisation of the drift from procedure in the management of non-engagement of service users. When asked about the discharge process in VC’s case, an interviewee told the investigation:

> “it came about in the same way as every other discharge I've seen. We’re trying our hardest. We cannot make contact with him. We don't know what his mental state is. We cannot monitor his mental state. Is he taking his

> medication? He's got a history of non-concordance. We knew that. But he does pick his medications up now and then. I was giving weekly inputs [to the MDT], really. Saying, “Well, with regards to [VC], I haven't seen him. I can't find him. He refuses to answer my calls. He doesn’t respond to my texts. So I can't really tell you much about what his mental state is.”

The interviewee went on to say:

> ”…I think by September [2022], I think it had just got to the stage where we talked about it as a team, and we just came to the conclusion that he's just refusing to engage with our service, and we agreed to discharge him back to his GP.”

Members of the EIP team relayed during interview that they believed that, as an MDT, they had considered all options and risks and had acted in line with guidance and their usual practice. However, staff acknowledged that the rationale behind their decision making, and the consideration and formulation of risk was not sufficiently documented within VCs records.

Finding

There was a drift in practices regarding the management of the service being unable to engage an individual in the context of the level of resources to support assertive practices. The Trust policy describes how the Trust imagines or perceives the work should be completed (being assertively outreaching to individuals). However, the reality and gap in capacity and demand directly influences necessary adaptations by frontline staff in the way work is really done.

Communication on discharge

A letter was sent to VC's GP on 23 September 2022, stating that VC had been discharged from mental health services due to non-contact. The letter did not contain any accompanying documentation such as a recent risk assessment or safety planning documentation. A phone call was not scheduled with the GP in advance or alongside the discharge to discuss risk factors or share any information they held about VC. Essentially the risk was discharged to the GP without them having any real understanding of VCs needs or risks.

Finding

The investigation identified that non engagement with the EIP team has become an accepted reason for discharge, recognising the context that the EIP team had made several requests to increase their ability to ensure engagement through a CTO and without this had limited ability to create a situation that enabled them to assess and deliver treatment in the community setting.

The letter was written by a senior colleague within the EIP team who did not have any direct contact with VC. Whilst there is nothing in Trust policy to stipulate who should send such letters, it is recognised that someone involved in a patients' care is likely to be best placed to share appropriate information about risk factors and management. Whilst staff could not recall why a senior colleague drafted the letter, the independent investigation team was told during interview that staff believe this was most likely done to support Care Coordinator 2 who was carrying a high caseload of service users with complex needs and risk factors. Care Coordinator 2's caseload was 20, this was five above advised limit epin-standards-first-edition.pdf (rcpsych.ac.uk) . This is discussed later in this section. During interview, staff acknowledged that it was unusual for someone other than the care coordinator to compile and send the discharge letter. The team also had a lack of administrative support since the uncoupling of the EIP team from the LMHT, which may have contributed to the timing and consistency in discharge communication processes.

Whoever is undertaking the task of discharge, the opportunity to consider what is known about the individual ahead of that discharge should be reevaluated in line with good practice. A part of this process is a review of last contact, last risk assessment and any new information held should be reviewed. Whilst interviewees told the independent investigation that VC's discharge was discussed at the weekly MDT, it was not documented, nor did it highlight the lack of a final visit to VC's known address. The independent investigation is not suggesting that this would have made a difference to the tragic subsequent events, however, it would provide a final assessment to inform whether the decision to discharge VC was in his best interest and that of the general public.

The quality of the discharge record did not meet the Royal College of Psychiatrist's best practice and lacked transparency on the decision making relative to associated risks and justification for discharge back to the GP, without direct communication with the GP.

Evidence presented in interviews with the independent investigation suggests that discharge due to lack of engagement was not unique to this case. An interviewee told the independent investigation: "They felt there was nothing else they could do... I think several teams would have discharged VC at that point…" Additionally, the clinical records suggest that VC had previously been considered for discharge on 17 January 2022 due to failing to attend a 5th consecutive appointment with the EIP doctor.

Finding

There appears to have been a drift in practices in the discharge of mental health patients back to the GP which has resulted in a lack of meaningful communication and planning to manage recognised risks.

Transfer of VC's risk and management does not appear to have been actively managed in transfer between the community mental health team and the GP. The Royal College of Psychiatry's guidance on Good Psychiatric Practice college-report-cr154.pdf (rcpsych.ac.uk) states: 'when discharging from care, the psychiatrist should inform the patient, the referrer and the primary care team about the possible indications for future treatment and how to access help in future.'

Interviews with staff within the primary care setting considered that primary care should be involved in discharge and long-term management planning of more complex individuals or those with a history of poor concordance or violence. Interviewees told the independent investigation that it has been common practice for patients to be discharged from community mental health teams without their involvement. They did, however say, that this is slowly improving, and they are seeing more examples of being asked for their input regarding decision making and planning for a patient discharge since this incident.

During interview, primary care staff raised the question as to whether primary care is the most appropriate healthcare setting to oversee long term management of particular patients.

> "if it's a negotiated plan, if we're happy to accept that plan, I think that's very reasonable. But particularly with severe mental health problems, I think it has to be either much more closely negotiated- So I'd be happy to agree with that with a few people, but not in those who are not engaging, history of violence, very unpredictable. I think that should rest fairly and squarely within secondary care, to monitor those people that are high risk."

The University told the independent investigation that they were informed when VC was admitted to hospital and said that they provided inpatient staff with their views on VC's risk in terms of risk in the context of the safety of wellbeing of VC and other university students VC had contact with. This appears to present an imbalance between the normal work practices on communication of – information appeared to

be shared with the university from inpatient healthcare teams that was not shared with the primary care team. The primary care team suggested there may be a perception in the wider healthcare services that the university mental health team were the core support to students within the area and that there may be a disconnect and low levels of communication between them and the university and acute settings.

The investigation heard of issues relating to the technical interfaces and presentation of information that impeded the communication of risk, specifically on discharge. The investigation heard primary care providers do not have access to the technical system, so are not afforded the same opportunity as community care settings to check in on patient details, they will only receive information if pushed from the system directly to them. This will influence the timing of information that informs them of the level of associated risk certain patients may present. The primary care team also highlighted that as their technical systems are designed to highlight urgency associated with medical conditions and the need for medical investigations or specific treatment, they do not alert them to potential risks of violence that may exist with patients under their care. They suggested that historically verbal communication from clinical teams discharging patients would have informed them of these risks, which meets the guidelines. There appears to have been a drift away from this practice with the acknowledgment that when it does occur, it is considered the exception. The investigation is unclear if the drift in this practice stems from workload and workforce issues described above or perceptions held across teams on which information is available or communicated via different systems.

The sharing of information across agencies relies upon an incident or event. This model of accessibility to information is reactive rather than proactive sharing of knowledge about potential risk. However, the investigation heard that the risk associated with data sharing and GDPR requirements may be perceived as greater than the risk of not sharing information across agencies in a way that optimises communication about potential risk.

At an organisational level there was no evidence of the governance and assurance process to ensure the quality of discharges and the adequacy of the Trust's policy. The evidence suggests that the Trust's approach to procurement and implementation of technical systems may not consider national guidelines or the expertise of staff to ensure a suitable interface design that supports service delivery.

Finding

Communication with primary care appears to be of low priority in the context of mental health patients treated within the Trust. The design, integration and accessibility to technical systems used across acute and community settings impedes access and visibility of patient risks to primary care clinicians.

In healthcare there is often an over emphasis on the patient to contact the system if they are unwell. However, with certain mental health conditions, it is difficult to recognise when you are unwell or that you need to access help, particularly if the nature of the illness makes the individual lack insight or be untrusting of the very service that is trying to treat and support them.

This model of working was confirmed during an interview with a Trust executive who told the independent investigation that there has been an over emphasis on a service user engaging voluntarily with the service rather than the other way round. They expressed a need to be creative with interventions and the way in which attempts are made to engage people. However, what is not clear is what 'creative' looks like, where that resource is expected to come from in the current service delivery model and at what point it is accepted that something else needs to happen, e.g., more formal mechanisms in place for treatment.

What appears to be lacking from the documentation and recollection in the decision to discharge, is consideration that VC's disengagement may have been a symptom of his paranoid state, and that his lack of trust of services may have signalled that his mental health was deteriorating. A previous example of this was when, VC failed to attend an outpatient appointment on 17 January 2022. This was documented as

being his 5th missed appointment. The EIP consultant psychiatrist documented 'we will discuss the plan at MDT on Thursday. Consideration will need to be given to discharge as [VC] has essentially disengaged and we have not been able to monitor him. Perhaps a conversation with his mum and course tutors to see if there are any concerns currently will be prudent before considering discharge'. In fact, two days later VC underwent a MHA assessment and a week later he was sectioned under the Mental Health Act and admitted for his fourth hospital stay.

Context of discharge

Whilst the above information can appear to suggest that a decision was made to discharge VC against process. It is important to understand the context in which that decision was made and understand the thought process which led to that appearing to be the right decision in that moment for both the EIP service and, by their judgement, for VC.

The difficulty in providing appropriate care that enables it to be meaningful for all is a fundamental hazard, which will impact the ability to manage or monitor risk and this appeared to play a significant role in informing the decision to discharge VC back to his GP.

Evidence suggests that high workload was a dominant factor in the decision to discharge VC. The independent investigation acknowledges that staff in the EIP at the time of VC's discharge were operating with higher-than-recommended caseloads. The guidance from the Royal College of Psychiatrists epin-standards-first-edition.pdf (rcpsych.ac.uk) states that full-time care coordinators should not have caseloads of more than 15 service users, which should be reduced pro-rata for part time staff. VC's care coordinator told the independent investigation that at the time of VC's discharge that he was managing an average of 20 cases. Managers within the EIP service confirmed that the care coordinator had a "high caseload". However, of critical importance with regards to caseload, is not just the numbers of the caseload but the acuity of the patients on the caseload and the evidence

provided to us was that there were more patients, and they all required significant input:

> "They're all problematic."[19]

Additionally, given the care coordinator was the only male within the team he often took on cases where the service user had a history of violence or sexually inappropriate behaviour, his caseload was therefore often not only high but also complex.

> "…the team said, "Well, look, just keep trying. Keep trying. Keep in touch with him." And I thought, "Yeah, I think I need to keep in touch with him and I will keep trying, but it's problematic." As I say, I had another 20 people to… so I couldn't… if I'd have had just [VC], as an example, an unrealistic situation, I could have been more assertive, shall we say, in my monitoring. I would have been chasing him down. I'd have been trying to find out what he was up to, what he was doing, how he was, and invite him to talk to me…."

Given the demand on time and no access to an assertive outreach function, the capacity was limited for Care Coordinator 2 to assertively attempt to find VC when he had been out of contact for a considerable time. However, the EIP operational policy at that time did describe an 'assertive approach to engagement'. This policy was updated in July 2022 and states that the purpose of this approach was to:

> "reduce the risk of service users being lost to services and potentially experiencing a longer duration of untreated psychosis. To assertively engage in situations where service users miss multiple appointments or are resistant to working with the team. The EIP will be flexible and creative in the approaches it uses to establish engagement with 'hard to reach' service users".

[19] ibid

The policy does not specify the frequency in which the service should contact service users nor whether there was a time period in which the service should remain open to service users who do not engage. Additionally, it is unclear from the EIP teams' caseloads and resources at that time, how that model of care could be achieved. Additionally, it is not clear what the oversight arrangements were for the Trust senior management to be aware of service concerns.

Finding

EIP staff were working with caseloads beyond the recommended level and the complexity and acuity of service users was not reflected in allocation of workload. There appears a lack of Trust oversight to identify signs in the ability for frontline staff to effectively deliver the model of care intended by the Trust.

As described in other sections within this report, staff were attempting to work in a least restrictive way as possible with VC. This was to support the fact that he was a young graduate, and staff were keen not to 'label' him too quickly with an enduring mental health condition. Additionally, staff referenced in interview that being a young black man meant that statistically he would have been more likely to have received restrictive interventions, and staff were conscious not to behave in a way which perpetuate this. Staff were having to manage competing demands and policies in order to deliver care which they considered to be the most appropriate.

At this time there did not appear to be a standardised process for involving primary care in discharge planning. This would have enabled for a system to be in place to enable a dynamic discussion about risk and for any concerns to be discussed as well as the opportunity to revisit potential other actions to take prior to discharge, such as contacting the family. However, this would have relied on having the resources within the team to embed such a process. Additionally, the community team at the time of VC's discharge from secondary mental health services did not have a discharge template in their electronic record system. This limited the guidance and record around the discharge process.

Finding

The absence of robust Trust discharge processes and a record template, which enabled engagement with primary care and the family resulted in limited consideration and quality in the effectiveness of the transfer of care and management of risks. The Trust told the independent investigation that a more robust approach to discharge from services has been included in the updated Transfer and Discharge policy (May 2024).

Despite the lack of documented decision making, the independent investigation acknowledges that VC's discharge back to primary care was made as part of an MDT meeting. However, the decision was not taken as part of a positive plan for VC's future management but rather because of the team's inability to have an ongoing impact on VC and following an extended time and attempts to engage and make contact. Based on interviews with Trust staff and from the evidence reviewed by the independent investigation, VC's discharge due to disengagement does not appear to have been an isolated event. Pressures on the service and a lack of oversight to understand whether the service was being delivered as intended, or whether 'as intended' is possible within the constraints of resources, meant that this practice had become normalised and accepted within the team.

Finding

The constraints around resources to manage disengagement and limited Trust oversight did not sufficiently alert the Trust to the normalisation of a compromised delivery of care.

As part of the decision-making process, it would have been prudent to revisit documentation such as care plans, safety plans and risk assessments and for staff to visit VC's new address and try to discuss these with VC. VC's last assessment in the community was undertaken in January 2022 (before his last hospital admission) and was therefore likely to need revisiting. In that assessment, VC's documented risk

to self and others was considered to be low, however this reflected the hospital setting and not his risks within the community. He did not have a crisis or contingency plan for the community which was outside of Trust policy.

Comment

VC's risk to self was always documented as low. It is unclear what this assessment is based on. However, the statistics suggest that individuals diagnosed with schizophrenia are significantly more likely to take their own lives than harm others. This also echoed concerns expressed by VC's family who believed that if they received a call one day regarding VC it would be to inform them that he had taken his own life, not that he had killed others.

VC's final risk assessment was documented on 28 July 2022:

> '…Risks to others – Male, diagnosis of paranoid schizophrenia, appears to experience persecutory delusional beliefs that thoughts can be influenced and controlled by computer systems specifically developed to interfere with the mind. [history] of violence and aggression when detained (significant assault on police officers), violence and aggression towards housemates and refused to let them leave property, poor insight, does not agree that he has been unwell over the last 12 months. Poor engagement with community services, history of non-concordance with medication'.

A discharge without a face-to-face review to establish VC's current mental state had the effect of limiting the judgment of remaining risk associated with VC's mental health at the point of discharge. During interview, staff acknowledged that VC had the propensity towards violence when unwell and in the context of being detained but that he had no history of carrying weapons. It was two months between VC's last risk assessment and several months since he engaged with EIP in a meaningful way to fully establish a grip on any potential risk or deterioration in his mental state. VC's risk was not fully understood at the point of discharge from services despite the efforts of the EIP to engage with him. However, from previous knowledge of VC's hazards, it was hard to rationalise a good outcome from discharging VC from mental

health services. Most likely, he would deteriorate and re-present to mental health services.

Interviews suggest that this is not a unique situation and discharge without a face to face consultation potentially appears to have become normalised. The medical model appears to treat discharge in similar way to a physical health condition, which does not infer risk to the public or to self. Whilst in some healthcare settings 'no news is good news', suggests no issues with a persons' symptomology, this model does not always meet people's needs in mental health. In mental health, the clinician is required to balance the goal of least restrictive practice with management of potential risk of harm to the patient and the public. Non engagement can be interpreted as choice by the patient, in the context that mental capacity has been confirmed, or as part of an illness. However, if a threshold is not met for an intervention, e.g., need for a mental health assessment, and the threshold for lack of mental capacity is met, then clinicians have few options available to them to enforce engagement. In this context mental health care, treatment and discharge rely on voluntary engagement.

Finding

Discharge in the absence of a face to face meeting with a patient creates the potential for greater risk to the person using mental health services and to others. Normalisation of such discharges appears to be influenced through demand on services tempered with limitations in non-restrictive practices that can still achieve engagement of patients reluctant to meet voluntarily with community based clinicians.

In order to understand the decision-making process, it is important to understand who held what knowledge at the point of discharge. Whilst the decision to discharge was made in an MDT meeting, it was made in isolation from other agencies such as the police and the GP. Contact with the police may have resulted in the mental health service being made aware that a warrant had been issued for VC's arrest.

Additionally, contact with VC's family may have provided another view on his wellbeing or whereabouts.

VC's family were not informed of his discharge to primary care in September 2022. Whilst VC had withdrawn his consent for the team to engage with his family in December 2021, the EIP team did manage to engage with the family on occasions in an appropriate manner. Despite VC withdrawing consent, the Trust policy entitled 'Information sharing between professionals, patients and carers', suggests that family communication can take place in such circumstances when it is the public interest to avert a risk of serious harm or is in the best interests of the patient. There did not appear to be a meaningful way to triangulate information.

7.5 Oversight, assurance, risk assessment and management

7.5.1 Governance, communication and oversight of safety related risks

The independent investigation looked at the management and oversight of safety related risks at Trust Board level and at Integrated Care Board level (ICB). It also considered the role of the wider system including engagement with the Police and the University.

This section starts with a review of the Trust board oversight, including review of the governance structures in place during 2020-2023 and how the Trust Board received and interpreted information and responded to safety risks. The investigation identified findings relevant to:

- limitations in organisational structure,
- challenges from organisational change,
- lack of processes for interpreting, learning and communication of risks.

7.5.2 Organisational structure influence on information quality

It appears to have been recognised at Trust Board level, from as early as 2019 that several factors influenced the quality and assurance of the information provided to the Trust Board;

> "Committees and board, the quality of the papers was not brilliant, committees listened to the presentations of the papers, accepted what was in them. I don't think there was as much challenge as you might expect. Certainly, assurance levels were not assessed in terms of the evidence that was given."

We heard evidence that attempts were made to address these governance issues, but the COVID-19 pandemic put an immediate stop to progress on subject:

> "People get criticised, don't they, for mentioning COVID in the middle of all of this. But I'd been in post just over a year when the pandemic hit, and that had an absolutely fundamental impact on my role [on the Trust Board]."

We heard evidence that the Trust Board met online for 18 months the impact this had on the Trust Board members' ability to compare the information they received at Trust Board with the information they picked up through face-to-face visits to service areas and meetings with staff, patients and their families:

> "So, that triangulation you get by visiting clinical services and talking to patients, talking to their families, talking to staff with what you're being told at board just disappeared overnight and disappeared for well over 18 months, if not longer. So, that was really difficult."

We also heard about the high level of change within the Executive Team and how this impeded the embedding of the changes required in terms of structures and culture:

> "There have been a lot of changes. So, in my time in the Trust, five directors of nursing. I've been here five years. People have come and gone, two chief executives, two chairs, a whole board change."

> "…So, X did make some very definitive changes. I think that was welcomed by clinical services and the board alike. But then, since then, as I say, there has been quite a lot of turnover of people. It's never, in my experience, a great thing. You need fresh eyes and fresh ideas, but when you get a lot of churn, you don't get that stability that you need to run a complex organisation like Notts Healthcare. I do think that has been part of the problem. People come in with new ideas and, "Oh, here we go. We're back on the let's-change-everything-around rollercoaster." It has felt like a rollercoaster, I have to say."

Finding

Ahead of the COVID-19 pandemic there was evidence to suggest that Trust governance structures and processes needed strengthening to ensure 'ward to board' viability of key information.

Finding

The investigation considers the impact of COVID-19 may have compounded existing issues around organisational structure and change. A lack of organisational stability, effective structures and processes impeded the visibility and oversight of organisational risks.

7.5.3 Interpretation of information relevant to risk of harm to others

The investigation considered the ability of the Trust Board to interpret information of the risk of harm to others from violence perpetrated by Trust patients.

Individuals with some types of mental disorder, notably schizophrenia, are more likely to be violent than others in the general population People with severe mental illness as the perpetrators and victims of violence: time for a new public health approach - The Lancet Public Health. The journal article states that:

> '…improving access to mental health services is likely to be an important area to improve violence prevention. A substantial proportion of people with schizophrenia, for example, are not currently treated fully in accordance with clinical guidelines.'

To understand how well this risk was understood by the successive Trust leadership teams, the investigation requested all incidents of violence perpetrated by Trust patients in the community between 2019 and 2023. We were provided with details of

violent incidents recorded on StEIS, which was the NHS national incident reporting system during the period in question.

7.5.4 Serious incidents of violence from patients in the community

The investigation identified that between 2019 and 2023 there were 15 incidents of patients either under the current care of the Trust or who had been discharged from the Trust, perpetrating serious violence towards members of the community. These 15 incidents did not include the homicides and attempted murders committed by VC. In some instances, the victims were members of the patient's own family or known in some way to the patient, but in other instances the victims appeared to be strangers. The level of violence in the incidents was extremely serious and in three cases resulted in fatalities, one of which was an individual who had been known to services. The majority of the incidents involved stabbings. All of the incidents were sufficiently serious to result in arrests and involvement with the criminal justice system, which is how they came to be reported on StEIS. The outcome of the involvement with the criminal justice system is not known for most of the incidents.

Most notably, in February 2023 there was an incident where a patient in receipt of mental health services from Nottingham Healthcare NHS Trust was arrested for stabbing five people over the course of a weekend. The report is unclear regarding the criminal charge for the arrest stating that that the patient was arrested on suspicion of Grievous Bodily Harm and attempted murder. There was no indication of whether the victims of the stabbings were known to the patient.

Communication to the Board

The investigation team reviewed the Trust Board papers for the Trust for the period 2019 to June 2023 to understand if these serious incidents were reported to the Board. We found very limited evidence regarding discussions of these particular serious incidents or subsequent investigations. There appeared to be an absence of action plans, review of actions or shared learning. We found only one instance where an incident involving violence was discussed by the Trust Board. In May 2021

a Non-Executive Director made an appropriate challenge to Executives regarding the discharge of a patient;

> [Non-Executive Director] raised a question …asking why the patient had been moved to a community setting so quickly after such a violent incident and whether there were any lessons to be learnt in terms of good practice.[20]

An Executive Director responded to this challenge by informing the Non-Executive Director that a learning event had been arranged for all involved. We asked the Executive Director who had informed the Board about the learning event whether it had happened, but they could not remember if it had. We also asked a Trust Board member if they could recall a learning event and they could not, but commented;

> "…people have promised learning events or to do things about it, but we have not had that kind of follow-up in terms of, "This is what we said, this is what we've done," type thing."

The investigation team could find no other supporting evidence that the learning event had taken place. It could well have been held but the fact that we could not find evidence that it was, such as a further report to Trust Board indicates that, if it did take place, it was not a strategic priority for the Executive Team to inform the Trust Board about the outcome of the learning event.

February 2023 incident

From the serious incidents involving violence in the community, we were particularly interested in whether the February 2023 incident involving multiple stabbings was reported at Trust Board and any actions that were taken as a result of it. The investigation could find no discussion of this incident in the Trust Board papers of

[20] Trust Board meeting Part B, May 2021

March and May 2023. We asked an Executive Director if it had been discussed at Trust Board and received the following reply;

> "… I've read the summary and where it was- so it's in the reportable issues log, as you say, just in private board. I've read the circumstances and I can imagine potentially why it wasn't discussed in huge amounts of detail in the sense that we weren't in a position to be able to investigate it until the November in terms of the police. And what's documented from the initial was that there was no immediate learning identified.
> And that's the level I would imagine that the discussion would have stopped at, having read the summary of what I've got."

Reportable issues log

Trust Board and Reportable Incident Log

The investigation identified that the Trust Board received details of all serious incidents through the Reportable Incident Log shared during the private session of the Trust Board meeting. However, we found that there was limited discussion by the Trust Board of the serious incidents included in the Reportable Incident Log. We reviewed the minutes of 27 Trust Board private sessions that included the Reportable Incident Log and noted the length of time the Trust Board discussed the Incident Log.

Table X: Table to show the length of time Trust Board discussed the Reportable Incident Log

Length of time	Number of occasions
1-6 minutes	12
7-10 minutes	5
More than 10 minutes	7

Source: Trust Board Meeting minutes (Part B) 2020-2023

The majority of incidents that were subject to longer discussion involved Prevention of Future Deaths report from Coroners. None of the longer discussions related to the serious incidents involving violence.

The discussions that did take place were reactive in nature responding to the individual incident only and limited attention was given to learning that might arise across incidents to prevent further occurrences of similar incidents in the future.

In addition, we noted that there was very limited thematic analysis of the serious incidents presented to the Board, which meant that the opportunity to identify thematic learning and address these themes strategically was missed.

Since this current investigation the Trust has completed a thematic review of homicide related incidents (August 2024) and shared the findings. In August 2024, an independent thematic report was produced into a number of homicides which occurred at the Trust between 2019 and 2023. Seven reports were identified as meeting the criteria for inclusion of the review (5 homicides and 2 attempted homicides). This review included consideration of the homicide committed by VC in June 2023. There were three further reports which had not yet been completed which fell within the timeframe. A number of emerging themes were identified in the report:

- **Poor engagement, lack of follow up and risk assessment** - In five cases poor engagement and noncompliance was evident in a variety of ways. In two cases patients were discharged due to non-engagement with community teams one at their own request and one due to lack of contact. In both cases there had been concerns about violence to others.
- **Delays and Waits** - Delays and waits were evident in four of the reports with little evidence of any stratification of risk regarding waits and delays, even when other agencies requested that a patient was seen early, nothing changed

- **Multi-agency working including safeguarding** - on several occasions a lack of curiosity of the patient's social situation. This was especially evident in two of the cases where there was an over reliance on what the clinicians were told and a minimising of risk. The report also identified a lack of inter-agency working and information sharing in some of the cases.

7.5.5 Sharing the learning around risk

There was evidence of a limited approach to the dissemination of learning around known systemic risks. This appeared due to a lack of cohesion within the Trust's governance structures between 2020 and 2023. We heard consistent evidence that from 2020 up to the appointment of the new Chief Executive Officer in December 2022, the governance structures at the Trust lacked standardisation, operated in silos and resulted in a culture of isolationism across the organisation:

> "To be quite honest, I felt it was peculiarly, strangely organised, in terms of the way that it was operating. …it [the structures] drove silo working through the organisation, restricted opportunities for learning."

> "there was absolutely a culture of a separate operating model in each care group, in each division."

The siloed governance structures meant that there was no vehicle by which dissemination of learning could take place and the Trust Board were not adequately informed of the proper nature of the patient safety risks.

The investigation heard that learning forums or groups and the theming of data now in place enables assimilation of learning from incidents or events. However, it is unclear how knowledge of capacity issues was and would even now be seen as a

signal for the system to interpret as a risk for quality of care but more importantly in terms of risk to staff and public.

Finding

The investigation established existing processes and organisational approaches to managing incident data and reports of events specific to harm to others did not support effective oversight and provide opportunities to learn. Furthermore, effective follow up actions to understand how the organisation intended to improve their approach to the management of this risk were absent. This highlights the absence of a robust approach to risk management with an absence of assurance to the Board on the evaluation and effectiveness of intended controls. A robust risk management approach would also include transparency of remaining risks to be held at Board level for which controls were limited.

7.5.6 Organisational and strategic risk management

We looked at the understanding and management of safety related risks at Trust Board level. This included reviewing the governance structures in place during 2020-2023 and how the Trust Board heard and responded to safety risks.

Our review of Trust Board papers identified that the Board was focused upon the strategic management of operational matters but did not strategically address how these operational matters impacted upon safety of patients and others. This point is illustrated in the paragraphs above when reflecting on how the Trust Board addressed the potential patient safety risks of increasing staff shortages and acuity of patients.

We found consistent evidence from different sources that patient safety issues were addressed in a reactive manner, rather than strategically by the Trust Board. A powerful example of this was the way in which the Trust responded to the number of Prevention of Future Deaths (PFD) reports it received between 2020-2023. There is evidence that they were fully discussed at Trust Board and actions were taken by the

Executive Team, such as establishing a Trust wide quality improvement group to reduce suicides. However, we could find limited evidence of assurance being provided to the Board about any progress made in implementing the actions of the improvement group. In the absence of assurance about progress, the effectiveness of the quality improvement group is called into question. In addition to the lack of assurance regarding the effectiveness of the quality improvement groups, there is evidence that the quality improvement groups acted in isolation which meant that learning was not shared across the Trust.

The example of the hazard of reduced workforce will be considered to illustrate the finding above.

There is consistent evidence that both the in-patient wards and community services experienced increases in workload and significant staffing challenges during the period 2020 to 2023. Added into these staffing challenges were the unprecedented challenges presented by the COVID-19 pandemic which required staff to adopt different ways of working.

The independent investigation has identified a lack of understanding across the whole organisation, from the frontline to the Board regarding how increased workload and decreased staffing numbers was impacting on the safety of clinicians' work.

The investigation identified a lack of recognition of a significantly increased workload combined with staff shortages and recent reorganisation of services had the potential to impact upon the safety and quality of services provided. We can see from the Trust Board minutes that the Trust Board were aware of the workload issue and that the Executive Team were highly focused on improving the situation. Yet we did not find any evidence in these discussions regarding any anticipation how these factors might impact on clinical aspects of care and treatment delivered to patients.

There appears little transparency or consideration of the complexity in which the system operates and how such hazards may contribute to the stability and safety of services. The current approach to the management of risk does not appear able to identify hazards and join the dots to how these may impact upon known risks such as risk to self or others to fully understand the implications and potential for harm.

Although the Board Assurance Framework (BAF) identified lack of staff as the Trust's number one strategic priority with a high score of 12[21], we could not find any evidence of a corporate response to the clinical risks this created for both staff, patients and the public. We have not seen any detailed risk assessments regarding the issues, nor controls that were put in place to mitigate the risks identified. In the absence of these corporate measures, the increased risks are absorbed by staff to deal with on a patient by patient basis.

Lessons and literature from safety science and other safety critical industries recognise workload and organisational pressures on performance as contributory factors to drift in work practices and precursor to major accidents (Rasmussen, 1997).

In other safety critical industries there would be a formal recognition, through a systems-based approach to risk management, of the potential impact of these factors and they would be considered from a strategic perspective, rather than left to individual professionals to resolve. We know that these factors were not considered strategically by the Trust. What is unclear is if these observations may be equally relevant in other Trusts as systemic approaches to risk management are yet to be adopted in healthcare more generally.

[21] Nottinghamshire Healthcare NHS Foundation Trust Board papers 7 September 2021 (private session).

Finding

The frontline risks created by workforce issues and the increased use of subcontracted providers did not appear to be visible at Board level. Instead the risks appeared to be primarily managed by community NHS staff who told the investigation they made efforts to regularly contact independent providers to share information and seek to identify imminent meeting dates.

Finding

The lack of a systemic and systematic approach to risk management prevents the Trust from fully understanding and mitigating known risks and provide transparency to risks absorbed by frontline staff.

7.5.7 The integrated Care Board (ICB)

An ICB is a statutory body which brings together NHS organisations and partners to improve population health and establish shared priorities within the local NHS. ICBs replaced Clinical Commissioning Groups as the local statutory NHS body on 1 July 2022. The ICB has responsibility for planning to meet local health needs, allocating resources, ensuring that the services are joined up, and overseeing delivery of health and wellbeing for their population. The new system places a greater emphasis on collaboration and shared responsibility for the health of the local population. This requires governance arrangements that support collective accountability between partner organisations for whole-system delivery and performance NHS England » Guidance on integrated care board constitutions and governance.

Whilst ICBs do not regulate Trust services, the relationship between ICBs and provider organisations (eg Trusts) is described as one of collaboration whilst the ICB are still able to hold the Trusts to account on delivery against contractual arrangements. Further information regarding the statutory duties of the ICB in relation to quality and safety as outlined in the Health and Care Act 2022 Health and Care Act 2022.

In this system, the ICB commissions the Trust to deliver a number of services. There are specialist services, such as the high secure inpatient setting which are commissioned by others and the ICB is therefore required to work alongside partners to share intelligence and triangulate knowledge of services within their region. Interviewees described that this fragmentation of commissioning can impact the ability to see the whole picture of quality, performance and safety at any one organisation. This is particularly important as the Trust historically, focused on delivering specialist services such as the high secure unit. ICB interviewees described their perception that the focus on specialist services impacted on the level of attention paid to other services such as the community mental health teams. An interviewee described that seeing local community mental health teams as a core function has been missing. However, the ICB informed the independent investigation that developments to increase service provision were being monitored by the ICB

and NHS England as part of the Long-Term Plan community transformation programme. Additionally, the ICB reported that NHS England reviewed progress on a quarterly basis and the developments were considered to be in line with the plan for the community service transformation.

Oversight and assurance

The ICB shared with the independent investigation, documentation relating to assurance around quality, safety and performance at the Trust in the 18 months leading up to the tragic events in June 2023. These are summarised below.

2022 Quarter 1- (prior to ICB being in place) The ICB reported that they were providing quality oversight and support to the Trust across a number of settings, including sub-contracted as well as commissioned services. They documented that the incident investigation process was lengthy which was affecting learning from incidents.

2022 Quarter 2 - (ICB established in July 2022) The 'due diligence' work required by NHS England to ensure the safe transfer of CCGs, acknowledged the existing level of scrutiny for the Trust. At the first NHS Oversight Framework segmentation review in that Quarter, the Trust was documented as requiring level 3 support. This means that NHS England and NHS Improvement regional teams would work collaboratively to undertake a diagnostic stocktake, to identify the key drivers of the concerns needing to be resolved. An increase in the number of out of area placements (OAPs) was also documented.

2022 Quarter 3 – During this period there was intensive CQC activity, with an inspection at Rampton Hospital in September 2022, and in November 2022 the publication of nine CQC reports across five services from inspections in March and April. The ICB reported that their involvement in addressing concerns arising from the CQC inspections was conducted through the ICB-led Quality Assurance Group (QAG).

2022 Quarter 4 - The ICB QAG proposed updated terms of reference which allowed the group to separate assurance around CQC actions, and the demands of quality oversight of subcontracted services.

From a performance perspective, assurance was provided by the Trust that recent increases in out of area placements were short term. These increases were related to quality concerns of an independent provider that were being addressed.

The ICB risk register was updated and reflected risks around the Trust's capacity to improve; and the number of inpatients with learning disabilities or autism (LDA).

2023 Quarter 1 - The ICB QAG noted that there was no central Trust oversight of CQC actions – the Trust were rolling out a new IT audit system (AMaT) which would provide the resource to support this oversight. Two Prevention of Future Deaths (PFD) notices were issued during this quarter. Both were critical of the Trust's investigation process which did not support candour and learning.

The ICB assessed the Trust in June 2023 to recommend remaining in need of level 3 support under the NHS Oversight Framework, with continued focus on embedding quality improvements.

Oversight and assurance arrangements

The independent investigation explored with ICB staff, the mechanisms they have in place to provide oversight of the services they commission within the mental health Trust.

The independent investigation learnt that there is a System Quality Group and a Quality Team who have a business partner relationship with the Trust. The members of the quality team attend meetings at the Trust in the areas they're partnered with, particularly around quality and safety. For example, representatives of the ICB would be invited to and attend the Trust's Quality Committee.

The independent investigation learnt that the System Quality Group is chaired by either the ICB Chief Medical Officer or the Chief Nurse. Providers (such as the mental health Trust) are invited, and they are normally represented by Chief Nurses and Medical Directors.

On 21 January 2022 NHS England published national guidance on System Quality Groups B0894-nqb-guidance-on-system-quality-groups.pdf (england.nhs.uk). It states that all Integrated Care Systems are required to have a System Quality Group. The focus should be on enabling quality improvement across the health and care system. This guidance replaces the National Quality Board's previous national guidance on Quality Surveillance Groups. In relation to the collection of quality data and intelligence, the document states that the ICB should collect data relating to homicides/unlawful killings – historic and ongoing, including action plans.

ICB interviewees told us that there is a shared collaborative risk profile which enables the ICB to raise any concerns they have about safety or quality and for the Trust to provide their version of events and contribute to the risk profile.

Interviewees also described a separate executive to executive meeting (ICB and Trust) where the oversight framework is reviewed in relation to performance. However, these did not come into effect until 2023/2024.

An interviewee described a reduced level of proactive monitoring with the move from CCGs to ICBs as there was a significant focus on cost reduction. They told the independent investigation that this led on occasion, to learning about issues through whistleblowing rather than through their own proactive mechanisms to assure quality and safety.

Several interviewees told the independent investigation that it was identified in early 2023 that the System Quality Group meeting needed to be strengthened. It was reported that in its then format, it did not allow for some of the risks that were

identified, such as not meeting the duty of candour and raising larger concerns about what else may be happening, in terms of quality and safety, if this was not being met.

Comment

The approach to identification and management of risk at that time did not adopt recognised practices to ensure controls are considered and evaluated for their effectiveness. As described earlier, groups referred to as 'Quality' do not infer management of risk as required to understand safety.

The ICB told the independent investigation that safety and risk do feature within the 'quality groups' and described how the Patient Safety Specialist Steering Group feeds into the Quality Assurance and Improvement Group. Additionally, the ICB reported that the Trust has been on an 'enhanced' level of oversight using the NQB guidance for quality risk response and escalation framework for ICSs since its inception in 2022 through which, quality, safety and risk management are all considerations.

Despite this, a number of interviewees from the ICB described some of the meeting arrangements in place before 2023 as informal but considered them to now be more developed and formalised. An interviewee stated that when the ICB began to formalise some of the intelligence sharing arrangements in early 2023 they identified that partners across the system, that commissioned different services within the mental health Trust, shared similar concerns to the ICB. The interviewee described that partner organisations were identifying similar themes around patient harms and:

> "a disconnect between a centralising, organising, oversight function within the organisation, and its various care groups."

In terms of providing oversight, an interviewee told the independent investigation:

> "the job of quality is the Trust, so it's our job to assure and oversee that…one of the ways we do that is having a presence in Trust working groups, Trust

committees at every level so that we can see how they're getting assurance themselves, and then review our sense of appropriateness or oversight."

Whilst the role of understanding quality of the services they provide sits with the Trust, an interviewee from the ICB told the investigation that there was an overreliance on the Trust informing the ICB of concerns and then the ICB seeking assurance from the Trust that steps had been taken to improve areas of concern rather than the ICB seeking to assure themselves.

Comment

Quality and safety represent two critical aspects of any organisation, but they are not the same. In healthcare, quality is associated with ensuring that healthcare services meet the needs of individuals and populations, and that care is being delivered in line with guidance, standards and best practice. Safety is ensuring that care is delivered without harm to that individual or others. Not having a clear understanding of the differences between quality and safety may prevent the robustness of systems to assure the appropriate management of risk.

Finding

There were limitations with the assurance and oversight arrangements at the Integrated Care Board in 2023. The arrangements were not formalised or robust to provide the opportunity to fully identify signals of issues with safety and risk. Nor were the governance arrangements mature enough to triangulate intelligence with partner organisations.

The ICB told the independent investigation that the operating model formalising arrangements came into place in July 2022. Whilst the 'collective ownership' model embedded in the ICS (Integrated Care System) made some of the contractual performance measures less formal/prescriptive the quality/safety/risk oversight measures and the escalation framework have been in place since July 2022.

However, interviewees considered that quality assurance arrangements were relatively informal before 2023. Some interviewees told the independent investigation this was due to the transition from the CCG with some roles and functions no longer being in place and having to provide the same function with a smaller team and a drive to make a 20% cost reduction. Additionally, others described quality oversight as being less formal during the COVID-19 pandemic.

Other interviewees described the dynamics of the ICB and providers relationship making it difficult to provide the same level of check and challenge with a national emphasis on collaboration. Others described a level of organisational maturity that simply wasn't there at that time.

The ICB shared the risk profile they created for the Trust for Q1 of 2023 (April – June 2023) which provides a snapshot of the ICBs understanding of where risk across the Trust lies and what mitigating actions are being taken. The risk profile highlights a number of areas of concern, primarily around not meeting safe staffing levels. The Care Quality Report: Special review of mental health services at the Trust (March 2024) includes reference to key concerns shared with them by ICB, which they also found in their review. System working - Care Quality Commission (cqc.org.uk)

In relation to safe care, one of the Trust's patient safety priorities for 2023/24 was to improve clinical risk assessment, management, and safety planning in support of reducing suicide and self-harm. There were a number of actions documented but under assurance it is documented that the ICB has 'limited assurance' in this area. Included was the following accompanying statement: 'Safety indicators are reported within the Trusts quality surveillance report and integrated performance reports to the board, it is presented at divisional quality operational groups, Trust wide quality oversight group and the Quality and Mental Health Legislation Committee. A review of the quality metrics is now complete, However, improved divisional reporting of actions taken and appropriate escalation is still in development…'

The ICB also tabled some of the metrics alongside where these areas are overseen and where they perform against others.

Sub Ind Ref	Sub Metric Name	Oversight Group	Operational Forum	Latest Data Available	NHT		
					Rank	Quartile	Perf
S035a	Overall CQC rating	QAIG	QII Group	Apr-23	53	Lowest	2 - Requires Improvement
S121b	NHS Staff Survey raising concerns people promise element sub-score	PCG	PCG/SFH/NUH/NHT	2022	57	Lowest	6.59/10
S059a	CQC well: led rating	SOG	Exec Leadership Group	Apr-23	55	Lowest	2 - Requires Improvement
S069a	Staff survey engagement theme score	PCG	PCG/SFH/NUH/NHT	2022	57	Lowest	6.92/10
S068a	Sickness absence rate	PCG	PCG/SFH/NUH/NHT	Dec-22	62	Lowest	7.8%

In terms of the availability of data to support the early identification of issues, an interviewee from the ICB told the independent investigation that it is an ambition to have a system-wide quality dashboard. The aspiration is that this will enable the ICB to have data to help to inform their quality insight visits.

An interviewee from the ICB discussed the April 2023 Quality Improvement Group meeting. Their sense was the Trust was telling them lots of things but were not assuring the ICB that they had a grip on the full range of services that needed to be deemed as safe.

When asked about the ICB's ability in early 2023 to identify concerns in a timely way, an interviewee said:

> "I think it is fair to say that there was quite a lot of siloing, in my view. I think it would be… You know, the Quality Team, around some of the areas that we had quality concerns around, we definitely surfaced through our reporting

channels, so through our Quality Committee. We were clear about some concerns there. But I think the link between quality and performance probably wasn't as strong as it could be. And I think also, from a mental health commissioning perspective, they weren't as strong as they could be. And also, I think the ways in which our teams came together, there was what was described as an informal touchpoint meeting set up."

They went on to say:

> "I think it was recognised that, at a certain level, there were concerns being circulated, but it was about how we got that message up to our board in a way that they could challenge, in the board-to-board space, effectively."

In response, the ICB informed the independent investigation that whilst it may have been felt by interviewees that, from a mental health commissioning perspective, that the link between quality and performance was not as strong as it could have been. Contract management was in line with the Standard Operating Procedure. Additionally, there were monthly mental health performance meetings which NHSE attended. There were also recovery action plans in place for any underperforming areas.

Regarding the Trust's processes in place to recognise early signs of issues with quality or safety, an interviewee from the ICB told the investigation:

> "I also think the organisation recognise that. It had a centralising function that was utterly disconnected to some of the care groups. And there weren't clear lines of accountability around who would be responsible for quality within the care group. And you could see that play out in their committees as well... Because some of the information that clearly would have sent some concerns for us, as an ICB, weren't really well understood or checked or being managed in a way that we would expect,"

An interviewee described that they considered that the Trust had lost situational awareness of what was really important to focus on. They felt that the development of the governance arrangements was taking too long which resulted in a gap around providing assurance across a range of services. Additionally, they described a sense of being overwhelmed and that the Trust were having to be reactive to situations as they presented. The interviewee did consider that the Trust were open to challenge posed by the ICB regarding the delivery of services.

An interviewee from the ICB described to the independent investigation the limitations around assurance if the Trust does not have a grip of issues:

> "I think in any system, physical health, or mental health, where people are minimising impacts or can't understand them, it doesn't matter what mechanisms you've got in place, you will struggle to, as a commissioner, see those. Because you can go into a Trust, into a ward, and you see what you see on that one day, don't you?"

The independent investigation learnt that the ICB carried out a thematic review of prevention of future death reports (PFDs) that had been issued to the Trust. PFDs are issued by coroners to a person, organisation, local authority or government department or agency (under the Coroners and Justice Act 2009) where the coroner believes that action should be taken to prevent future deaths.
The independent investigation asked interviewees from the ICB whether there were any themes identified in their thematic review of PFDs which were also present in issues identified in the care and treatment provided to VC. They responded that there were themes around:

- assessment and formulation of risk,
- how information was collated around medication management,
- lack of engagement with families around concerns,
- how the organisation responded to disengagement.

Finding

Evidence suggests that whilst the ICB were aware of concerns regarding risk and safety at the Trust, they were not fully assured around the ability of the Trust to make or sustain the required improvements.

Whilst there is evidence of the ICB monitoring concerns, the arrangements in place to assure themselves of appropriate action being taken were still maturing and did not allow for the ICB to assure themselves of improvements in a timely manner.

Escalation of concerns

The ICB described having “lots of touchpoints” with CQC where they were sharing intelligence around the concerns they had around quality and safety at the Trust. An interviewee from the ICB told the investigation that these arrangements were ongoing from Easter 2023.

The ICB also described the presence of NHS England quality representative at the QSRM (Quarterly System Review Meeting). Interviewees told the independent investigation that regarding the services the ICB commissioned at the Trust, NHS England would have known about the concerns they were raising. Particularly around trends and themes around issues such as restrictive practice and compliance concerns the ICB had. Additionally, around the concerns the ICB were raising around incident-management and the themes and trends that were emerging from the incidents.

Finding

Evidence suggests that at all levels of the regional healthcare system, there was a level of knowledge about the challenges faced by the Trust. Despite this knowledge, the risk remained for Trust frontline staff to manage.

An ICB interviewee told the independent investigation that there is now better oversight of the Trust:

> "The reason we have a much better oversight now as well is because the Trusts have a greater understanding and openness and structure for reporting, and therefore we see more because more is being brought to light and as every stone is lifted. So we are there present with the Trust to see and help resolve and help work through the issues."

Further, the ICB told the independent investigation that the outlined strengthening approach of ensuring a joined-up approach to sharing conversations across quality, commissioning performance and risk is being scoped and worked through to enable effective intelligence sharing.

An interviewee from the ICB told the independent investigation that there are a number of rapid improvement programmes on going at the Trust. A rapid improvement programme is a targeted intervention to bring about improvements in quality, safety and outcomes in a given area. These programmes are closely monitored and have a set of clear objectives which need to be achieved. The ICB attends meetings relating to the rapid improvement programmes in order to provide a level of challenge. The ICB then brings intelligence back to an ICB "internal touchpoint' where performance, quality and risks are articulated and triangulated.

An interviewee from the ICB told the independent investigation:

> "We are developing a much more strengthened approach to having a conversation in a structured way, where quality commissioning, performance risk…is anchored around a much more formulaic way of going through the levels of concern about areas where we would like to see improvement."

Comment

As detailed above, the arrangements at the conception of the ICBs did not appear to be robust enough to systematically assure themselves of the quality of services they commissioned. Interviewees reflections regarding why some of the arrangements weren't as robust at the start are detailed above but include a focus on cost reduction and therefore the inability to undertake proactive spot-checks on service quality.

Finding

The processes in place for oversight and assurance did not provide a systematic approach to risk management.

An interviewee told the independent investigation that since the recruitment of the Trust's new chief nurse there has been a real sense of rigour around the pace that is needed to achieve the changes required at the Trust. In turn, the ICB reported feeling a greater sense of assurance around the biggest concerns they have around quality and safety. This has also resulted in a greater transparency with the ability to have candid conversations.

Going forward, an interviewee from the ICB considered that the biggest challenge for the Trust now is "holding the ring" on all the things that need to be fixed whilst going through a repurposing. This includes, how workforce changes are going to impact upon the services, particularly adult inpatients, community services, and some of their outreach Crisis teams. Also, the pace of change required for the necessary improvements requires real energy and resilience from the workforce. However, there is a real sense that a lot of staff are "really broken. Utterly broken… you can feel it".

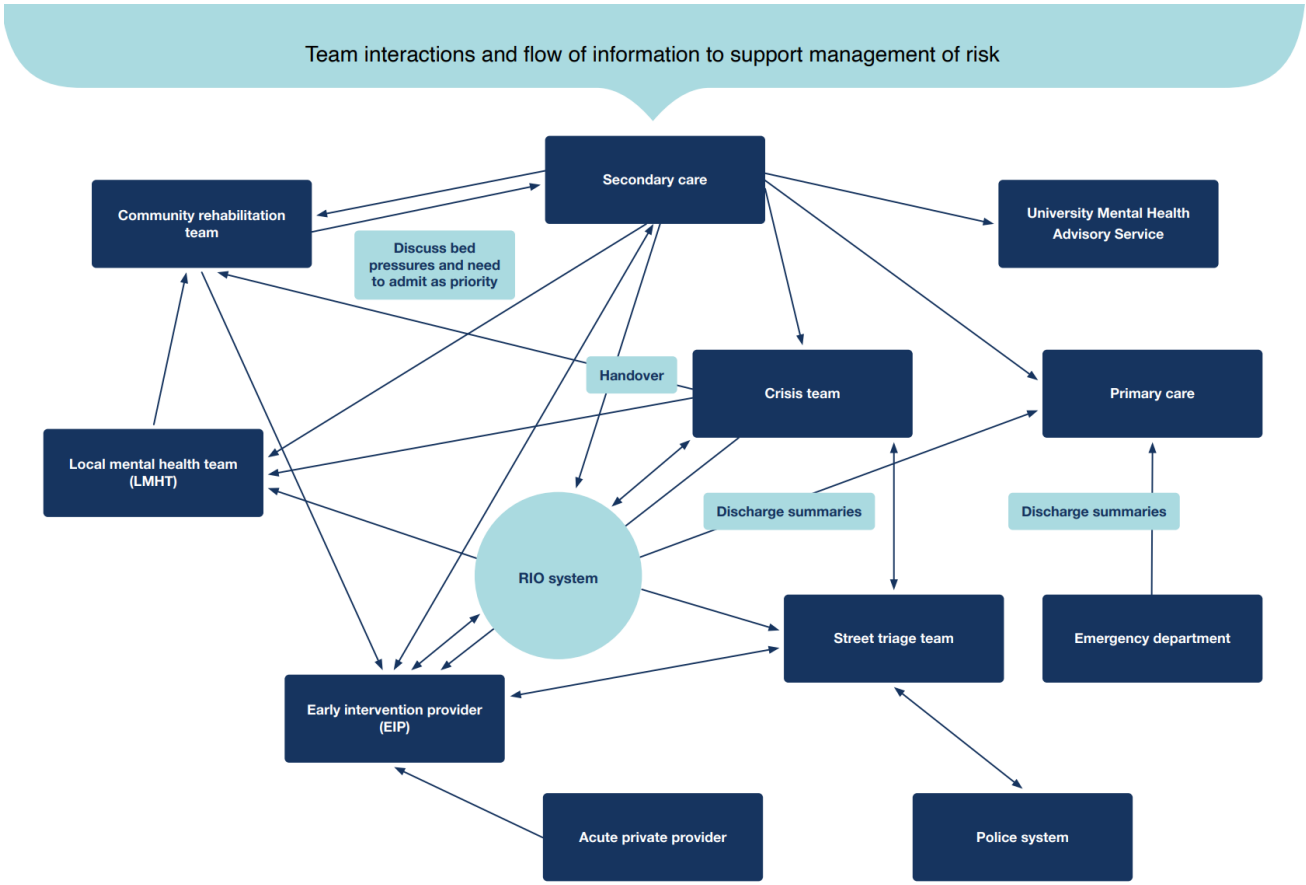
When asked what would help enable the change that is required, they responded that the Trust needs "permission to make the changes that need to be made".

However, they felt it was bigger than that in that there is something about the way that services are commissioned which makes service delivery difficult:

> "You've got a reducing bed base, you've got risk being held in the community space, you've got Crisis teams under huge pressure, making decisions…at pace. And knowing that there isn't the bed base potentially to enable really unwell people to receive treatment…Do we need to re-think how we deliver mental health services in the way they're configured? It's multi-layered. The cross between the social justice, criminal justice system and mental health is again…it's a structural issue, but I think it predicates itself and is played out in the community quite often."

7.5.8 The wider mental healthcare system

The section on care and treatment describes guidance that requires interdisciplinary management of existing risks. This recognises the dynamic nature of the risk and the need to manage the risk in deterioration of VCs condition in all relevant contexts. These contexts include inpatient and community care, public spaces and the University he attended. Delivery of care has described the disconnect across inpatient and community services. However, this appeared to be somewhat improved when all teams involved are NHS providers, as there is some ability for systems to communication compared to independent provider services interacting with NHS Trusts.



The diagram above shows all the different teams involved with VC and where different information regarding risk could be held.

The management of risk appeared to be impeded by those required to manage the risk not considering all available information from across the system to inform the assessment of risk. The cues or signals of deterioration were, at times, limited to one interaction at a time rather than a wider consideration of information across the breadth of the system and triangulation of interagency knowledge. On occasions when for example, Care Coordinator 1 did recognise the risks and tried to convey their views that steps should be put in place to mitigate risks (eg use of depot medication or a CTO) the responsible clinician's decision appeared to be based on their interaction with VC at that time.

There appears a lack of consideration of the views of VC's family, the voice of community teams and the university mental health support team in decision making around discharge back to the community. Staff within the EIP service were clear that, in their view, they did not have sufficient controls available to them to manage the hazards VC presented with, which included a lack of insight into his illness, masking of symptoms and non-engagement with EIP services.

The Trust had previously recognised an issue relating to poor engagement with families during the discharge of patients from secondary mental health services. Yet the impact of this poor engagement on effective management of risk does not appear to have been understood or appreciated.

The University

The University provides a range of support services which students can access if they are unwell or require assistance from a wellbeing perspective. The MHAS is one of these services.

The Mental Health Advisory Service (MHAS) is an advice and support service, designed for a higher education setting and available to help students who experience significant mental health difficulties to maximise their experience at university. The staff working in MHAS are university employees.

MHAS is not registered with the Care Quality Commission and does not provide clinical care in the way the NHS services do; its primary focus is to assist students who use its services to develop strategies to enable them to maximise their university experience and achieve academic goals.

There is evidence that the University's MHAS proactively contacted the mental health Trust on a number of occasions as outlined in the chronology section of this report. The university told the independent investigation:

> "In certain circumstances and wherever possible with a student's knowledge and consent, MHAS shares relevant information with other agencies, primarily to support students' access to these agencies and, where necessary, to assist these agencies in their assessment and management of risk for a student."

The University told the independent investigation that while they were aware to some extent, of VC's mental health difficulties, their involvement was largely liaising with the NHS Trust responsible for VC's care and flagging the University's concerns in relation to risk. The concerns raised to the mental health Trust by the University were primarily related to incidents involving VC in third party student accommodation. The University sought to mitigate the risk, including at one point liaising with the management of a third-party student accommodation site who arranged for students affected by the January 2022 incident to move into alternative accommodation. VC did not engage with MHAS and in February 2022 he withdrew consent for the hospital to share information with the university; however, sharing of concerns by the University was agreed on a need-to-know basis.

The University told the independent investigation that they raised concerns to mental health services at the Trust relating to VC's risk on at least six occasions between June 2020 and February 2022. Those concerns were all in the context of student welfare and were primarily focused around concerns about VC not returning to previous third party student accommodation after incidents had occurred there. Evidence of these concerns being raised by the University can be found in VC's clinical record.

Evidence suggests that the University made efforts to share their concerns with the mental health Trust – both through communication with ward staff when VC was an inpatient and then with the EIP service when VC was in the community.

It can also be ascertained, by comparing information provided by the University to information provided by VC's GP, that the University was, on occasion, informed of decisions in VC's care on the same day those decisions were taken, when statutory

agencies such as VC's GP were not. For example, on occasion when VC was detained under Section, it appears that timely communication occurred with the University, but the GP was not informed until sometime after discharge. Whilst it is positive that the University was sharing their concerns with the Trust around risk, their remit when it came to VC was limited by virtue of the fact that the University was not providing a clinical service and was not responsible for providing support for VC in the community. Therefore, it is important to ensure that key information such as risk concerns and discharge from hospital is shared in a timely manner by the Trust with the GP.

The Police

The management of risk for patients who are known to the Police and may have a history of violence seems significant to VC's case. As described in section 5 (Analysis of the Trust's serious incident investigation report) Nottinghamshire Police were unable to engage with the independent investigation as they remain under investigation by the Independent Office for Police Conduct (IOPC). However, the independent investigation has sought to understand the information sharing arrangements from the prospective of the mental health Trust.

There are formal arrangements in place for information gathering and sharing between the police and the mental health Trust. One of the mechanisms is via the Multi Agency Public Protection Agency (MAPPA) meeting. Documentation records that VC was not known to MAPPA, which implies he did not meet the criteria of MAPPA involvement.

MAPPA is the statutory process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders in order to protect the public (MAPPA_Notes_and_Definitions.pdf (publishing.service.gov.uk)).

As VC was not convicted of a crime, the only category that may have been relevant to consider the introduction of MAPPA would appear to be category 3.

‘Category 3 - Other Dangerous Offenders. These are offenders who do not qualify under Category 1 or 2 but have been assessed as currently posing a risk of serious harm. The link between the offence they have perpetrated and the risk that they pose means that they require active multi-agency management.’ (MAPPA_Notes_and_Definitions.pdf (publishing.service.gov.uk)

In this category the action would require multi agency cooperation for the development implementation of risk management plans. This may include at least the sharing of information across agencies or can include regular cross agency meetings.

There are many service users, as in VC’s case, who do not meet the threshold to be discussed in such a meeting. Despite not meeting the threshold, there are service users who have demonstrated a propensity towards violence and their behaviour has escalated within a relatively short period, such as VC.

Due to the police not being able to engage with this independent investigation, it has not been possible to explore the line of enquiry around the threshold set and the definition applied to judgements on the appropriateness of MAPPA, therefore no finding can be suggested.

The Trust shared, with the independent investigation, the 2017 Standard Operating Procedure (SOP) between the Trust and the Police which states that its purpose is to: ‘ensure consistency with regard to Criminal Justice liaison across the Trust.’ Also, to ‘support positive joint working and the appropriate flow of information between the Police, the Trust and their partners and all Criminal Justice agencies in fulfilling the shared responsibilities towards the public’.

The independent investigation learnt through interviews that Trust staff can request information from the police regarding an individual known to the mental health service. However, there is potential to improve the speed at which information is shared:

> "I suppose having access to a bit more joined-up learning with the police would be helpful. Because obviously, like we say, we do work with people that have that forensic background, and we do request those PNC [Police National Computer] checks, but they can take several weeks or months to come through. So perhaps that little bit more joined up would be really good".

A Trust executive told the independent investigation about a portal which has now been created in order for the mental health service and the police to share information on people who might not meet the MAPPA criteria. This initiative came into place after VC was known to Trust services. The executive told the independent investigation:

> "…the portal would be a good place. I think that, maybe, there- actually it would work, wouldn't it, because I don't think those risks were triangulated between the police and the team. Had they been, and we'd looked at the risk over the long term as opposed to just what was in front of them, it… I'm not saying it would've prevented what happened but there might have been other opportunities…"

Comment

The investigation recognises this is a positive step but recognises providing a portal to communicate risk would need to be supported through technology capability that can provide the relevant alerts to new or modified state of known risks. This may assist as a control to support the communication of information, however, it would need evaluation and assurance at Trust board level to its level of effectiveness in improving cross agency communication and contributions to risk management.

Finding

There were limited effective processes in place for ensuring the sharing of knowledge between the Trust and the Police to inform estimation of risk and insight on effectiveness of care and treatment.

Another area in which mental health staff and the police have the opportunity to work together and share information is through street triage. Street triage involve mental health professionals collaboratively working with police officers, attending scenes and offering tailored interventions to ensure individuals receive the most appropriate care, often enabling diversion from unnecessary custody. An interviewee told the independent investigation:

> "…there was only one team who saw everything police-wise and mental health-wise, and that was the street triage team."

Comment

The system relies on an act of violence or public disturbance to guarantee cross agency communication. The investigation heard the perception held by clinical staff, influenced by previous engagement, influenced their decision making to report VC to the Police. Despite the SOP and arrangements in place with the police, limited discussions appeared to have taken place at potentially key moments, such as the point when the EIP were considering discharge back to the GP.

Finding

Organisational structure, processes and technical systems create limitations in ensuring the reliability and quality of safety critical information is available to all relevant stakeholders. Without appropriate mechanisms in place, there are limitations with the timely sharing of important information to those involved, including the family.

Comment

The communication of risk does not appear to have been considered as an organisational risk to be managed. The multiple teams across different providers, reorganisation of services, workforce challenges and a lack of Trust oversight contributed to a drift in communication practices. These were not in line within recognised guidelines and contributed to a lack of visibility of the risks being held by the different clinical and educational settings.

The organisational structures and processes impeded the ability to learn from frontline experiences and incidents. This appears to have had a detrimental impact for the organisation to be proactive in addressing or increasing their understanding of the scale of the risk they were currently holding.

Summary of key findings

In this section, key findings from each main area of the report are documented. The full findings are contained within the main report.

Key findings in relation to VC's care and treatment

Finding

The current approach to risk assessment does not appear to focus on evaluation and evidence of the effectiveness of the controls in place to manage relevant risks. The clinical judgment made on discharge from hospital will have made sense based on observations and conversations with VC at the time. However, in the community context, the information inpatient clinicians relied upon to make their decision was contradicted by the observations of staff seeking to engage VC and his family. The context of care would seem a critical factor for risk assessments completed across inpatient and community teams to understand the implications for the reliability of approaches to risk mitigation and decisions around treatment and discharge.

The way in which risk was being documented and formulated was not indicative of a dynamic approach to risk assessment and management. That is to say, risk was not considered to be changeable based on the presence of known hazards and in the context of different settings. For example, VC's risk in hospital would have been different from when in the community where hazards such as non-concordance and disengagement from services may have led to risks. The risk assessment's formulation section reads as a list of previous violent behaviour rather than a true formulation and therefore does not demonstrate active risk control or understanding of the impact in change of effectiveness of protective factors. In the community, the section of the risk assessment form does not detail the actions taken or needed to attempt to minimise or mitigate known risks. Hence, reviews may not focus on how effective the intended controls were at that time or in the context of the setting.

Finding

The voice of VC's family was not effectively considered to support the dynamic evaluation of risk.

Finding

The prioritisation of a positive risk management approach may have impacted the ability to achieve medication concordance, engagement with services and an increased level of insight. Instead, a dynamic approach to risk management would provide the opportunity to consider clear points at which to move from positive risk management to taking a more restrictive approach. This would support the management of hazards as they presented and ultimately support VC with the long-term management of his mental health condition.

Finding

VC's concordance with medication was in question shortly after each discharge from hospital. Sometimes his partial concordance was explained away by his misunderstanding of the number of tablets to take at a time and by forgetting to collect his medication. Even when under close observation by the Crisis team in January 2022, they experienced difficulty in determining his medication concordance.

On each hospital admission there was an opportunity to consider putting in place arrangements for depot medication. This was not agreed to by VC and the decision was made not to administer depot medication. By the time VC was on his fourth admission there was a pattern of concordance in hospital and non-concordance in the community both with his medication and with his willingness to engage with his clinical team.

During his admissions under Section 3 of the MHA, there was the option to discharge VC under a community treatment order (CTO). A CTO can incorporate conditions, including a condition to comply with depot medication, with the option of recall to hospital if non-compliant. This provides a level of compulsion in the community that is otherwise not possible. The EIP team were seeking this intervention for VC to support his engagement when he was disengaging from services. A CTO could have also provided VC with the opportunity to explore how he felt when he was appropriately medicated.

The inpatient teams involved in VC's care were trying to treat VC in the least restrictive way and took on board VC's reasons for not wanting to take depot medication which included him not liking needles. His wishes were balanced against the fact that he was judged to have capacity and taking his medication on the ward which assured the team he was willing to take his medication in the community and work with the community team. On the fourth admission he was not displaying active symptoms of psychosis and the clinical team considered that they could not justify a move to a Section 3 of the MHA at that time. The early use of a CTO provides the opportunity to recall an individual to hospital in the event of a deterioration in the community under the CTO provisions within the MHA.

Finding

A theme running through VC's clinical records is that he did not consider himself to have a mental health condition. His insight into his condition did not appear to increase and therefore his understanding of the importance of medication in his case never appeared to be understood by VC. Whilst he may have clinically improved during his inpatient stays, he did not demonstrate retrospective insight. This is an important factor to consider when looking for an understanding of an individual's mental health.

Key findings in relation to VC's capacity

Finding

VC's ability to fully understand the implications of his mental health condition were limited by his lack of insight. This may have meant he lacked full capacity to make decisions in relation to his care and treatment and engagement, particularly in the community. There does not appear to be a systemised approach to assessing patient capacity based on presentations across care settings and relied upon in the context of voluntary treatment within the community. Therefore, the question of capacity does not appear to inform all assessments of risk across the different care settings.

Key findings in relation to the use of sections under the Mental Health Act and consideration of a Community Treatment Order

Finding

The investigation team consider that whilst decisions made were thought to be appropriate by those involved at the point at which they were made, what appears to be missing is shared decision making across all teams involved in VC's care. The community team fed into discussions about VC's care and their concerns about his non-concordance in the community. However, ultimately the decision appears to lie with the inpatient consultant as the Responsible Clinician. There are complexities with the Responsible Clinician having to make a clinical decision when the individual's presentation contradicts what is being reported from a longitudinal perspective.

The way that the system is configured, the emphasis is placed on the inpatient Responsible Clinician to make discharge decisions. If the system required inpatient and community consultants to have shared responsibility and joint decision making, then the autonomy of a single clinician (Responsible Clinician) might avoid the dominance of a perspective based on observations from one clinical setting.

The guidance states that, if the individual has a care coordinator in the community, then they should be involved in any discharge planning. Guidance also suggests that families or carers should also be involved in discharge planning. However, interviews from this investigation suggest that ultimately the Responsible Clinician makes the discharge decision. There is therefore a bigger question about why the culture appears to promote an individual in a specific role making the decisions even if this is at odds with the guidance and views of others involved in an individual's care.

Key findings in relation to the use of assertive outreach

Finding

NHS England's recent review and guidance indicates that assertive outreach should be a discrete resource but recognises while some ICBs may already commission 'assertive outreach' teams or similar, others may not currently commission a specific team or service focused on intensive and assertive approaches. This aligns with the information and evidence provided to the independent investigation that suggested the majority of dedicated assertive outreach teams as a standalone function, were disbanded over 10 years ago. Alternative models for supporting service users who do not choose to or are unable to engage with mental health services have developed but there is variation in the approach, dedicated protected resources and in outcomes for patients. VC's clinical records and interviews with community Trust staff do, to an extent, demonstrate an element of an assertive approach. However, this was constrained by the service model and workload within the team.

Key findings in relation to the use of out of area placements

Finding

Nationally, it is recognised that it is best to deliver care locally wherever possible and the aspiration is to not use spot-purchased out of area placements. In VC's case, the Trust had to send VC to a PICU bed and then an acute bed out of area due to a lack of local capacity. Whilst the records suggest that he received regular assessments and, where possible, Care Coordinator 1 attended ward rounds virtually, it is recognised nationally, that something is lost by not keeping care delivery local. In VC's case, this admission came at an important point in his mental illness, in that a pattern of his engagement as an inpatient versus in the community was forming. This may have been the opportunity to fully see the pattern and to take seriously the concerns of Care Coordinator 1 and consider using the time VC spent on a Section 3 to explore a Community Treatment Order.

Key findings in relation to the discharge back to primary care

Finding

The absence of robust Trust discharge processes and a record template, which enabled engagement with primary care and the family resulted in limited consideration and quality in the effectiveness of the transfer of care and management of risks. The Trust told the independent investigation that a more robust approach to discharge from services has been included in the updated Transfer and Discharge policy (May 2024).

Finding

The investigation identified that non engagement with the EIP team has become an accepted reason for discharge, recognising the context that the EIP team had made several requests to increase their ability to ensure engagement through a CTO and without this had limited ability to create a situation that enabled them to assess and deliver treatment in the community setting.

Finding

Discharge in the absence of a face-to-face meeting with a patient creates the potential for greater risk to the person using mental health services and to others. Normalisation of such discharges appears to be influenced through demand on services tempered with limitations in non-restrictive practices that can still achieve engagement of patients reluctant to meet voluntarily with community-based clinicians.

Finding

There appears to have been a drift in practices in the discharge of mental health patients back to the GP which has resulted in a lack of meaningful communication and planning to manage recognised risks.

Finding

EIP staff were working with caseloads beyond the recommended level and the complexity and acuity of service users was not reflected in allocation of workload. There appears a lack of Trust oversight to identify signs in the ability for frontline staff to effectively deliver the model of care intended by the Trust.

Finding

The constraints around resources to manage disengagement and limited Trust oversight did not sufficiently alert the Trust to the normalisation of a compromised delivery of care.

Finding

Communication with primary care appears to be of low priority in the context of mental health patients treated within the Trust. The design, integration and accessibility to technical systems used across acute and community settings impedes access and visibility of patient risks to primary care clinicians.

Key findings in relation to oversight, assurance, risk assessment and management

Trust oversight

Finding

Ahead of the COVID-19 pandemic there was evidence to suggest that Trust governance structures and processes needed strengthening to ensure 'ward to board' viability of key information.

Finding

The investigation considers the impact of COVID-19 may have compounded existing issues around organisational structure and change. A lack of organisational stability, effective structures and processes impeded the visibility and oversight of organisational risks.

Finding

The investigation established existing processes and organisational approaches to managing incident data and reports of events specific to harm to others did not support effective oversight and provide opportunities to learn. Furthermore, effective follow up actions to understand how the organisation intended to improve their approach to the management of this risk were absent. This highlights the absence of a robust approach to risk management with an absence of assurance to the Board on the evaluation and effectiveness of intended controls. A robust risk management approach would also include transparency of remaining risks to be held at Board level for which controls were limited.

Finding

The frontline risks created by workforce issues and the increased use of subcontracted providers did not appear to be visible at Board level. Instead, the risks appeared to be primarily managed by community NHS staff who told the investigation they made efforts to regularly contact independent providers to share information and seek to identify imminent meeting dates.

Finding

The lack of a systemic and systematic approach to risk management prevents the Trust from fully understanding and mitigating known risks and provide transparency to risks absorbed by frontline staff.

Integrated Care Board (ICB) oversight

Finding

There were limitations with the assurance and oversight arrangements at the ICB in 2023. The arrangements were not formalised or robust enough to provide the opportunity to fully identify signals of issues with safety and risk. Nor were the governance arrangements mature enough to triangulate intelligence with partner organisations.

Finding

Evidence suggests that whilst the ICB were aware of concerns regarding risk and safety at the Trust, they were not fully assured around the ability of the Trust to make or sustain the required improvements.

Whilst there is evidence of the ICB monitoring concerns, the arrangements in place to assure themselves of appropriate action being taken were still maturing and did not allow for the ICB to assure themselves of improvements in a timely manner.

Finding

Evidence suggests that at all levels of the regional healthcare system there was a level of knowledge about the challenges faced by the Trust. Despite this knowledge, the risk remained for Trust frontline staff to manage.

Finding

The processes in place for oversight and assurance did not provide a systematic approach to risk management.

Wider system oversight

Finding

There were limited effective processes in place for ensuring the sharing of knowledge between the Trust and the Police to inform estimation of risk and insight on effectiveness of care and treatment.

Finding

Organisational structure, processes and technical systems create limitations in ensuring the reliability and quality of safety critical information is available to all relevant stakeholders. Without appropriate mechanisms in place, there are limitations with the timely sharing of important information to those involved, including the family.

Recommendations

National recommendations

Area for improvement 1 – Care delivery

We found that the offer of care and treatment available for VC was not always sufficient to meet his needs. This included the service having difficulty in providing VC with support when he did not wish or was unable to maintain contact with services. From conversations with others as part of this review, we believe that the experience of VC was not unique in how some people with severe and enduring mental illness are supported by mental health services.

We recognise that NHS England is aware of the need to improve the quality and effectiveness in a number of areas and has developed several programs of work to drive this forward to improve the outcomes and experience for people who use mental health services. Our findings suggest that there needs to be significant continued focus at all levels to meet the mental health needs of people and the communities served.

Recommendations

NHS England and other national leaders, including people with lived experience, should come together to discuss and debate how the needs of people similar to VC are being met and how they are enabled to be supported and thrive safely in the community.

National leaders should, in the next six months, include, as part of this debate, the following key areas:

- The demands on mental health services have increased over recent years. Services are often delivered across complex multi-agency systems. People who use mental health services frequently have multiple needs that require significant support to enable them to live well. National leaders must be

confident that the financial resources currently available are sufficient to meet the needs of those experiencing severe and enduring mental illness.

- What safe and effective delivery of care should look like for those with severe and enduring mental illness. This should include the consistency of oversight of care across inpatient and community services including the use and application of relevant parts of the Mental Health Act.
- The debate should ensure that the resources for the community model of care are sufficient to meet the needs for severe and enduring mental illness and is supported by an appropriate number of inpatient beds in the context of increasing demand and acuity. This must be supported by sufficiently trained and developed workforce, including people with lived experience.
- The dissonance between what people think should be happening, for example care described in national policies and guidance compared to what is actually being delivered in some services.
- The community mental health framework may have led to an unintended consequence of easing of oversight of some people with significant needs through the removal of the Care Programme Approach aspect of care. National leaders should assure themselves that there aren't negative consequences of some of the actions.
- That care for those with severe and enduring mental illness is commissioned and delivered in line with evidence-based practice and co-produced with people with lived experience. Commissioners should assure themselves that services they are commissioning are being delivered as intended.
- Whether the recurring, common themes that are identified in similar reviews are an accepted risk in the system or whether there are fundamental changes that can be made to mitigate these risks further.

Area for improvement 2 - Risk

We found that risk, both to the individual and potentially to others, was not fully understood, managed, documented or communicated in VC's case. Discussion with national experts and those with lived experience suggests that this issue is not isolated to this case.

Recommendations

NHS England should, in the next six months consider:

- How mental health and social care understand the concept of risk, risk assessment and risk management systems to ensure the effective identification and evaluation of risk across all care and public settings, together with the appropriate implementation of adequate safety measures.
- What mechanisms are in place to communicate risk across multiple agencies to hold, share and communicate risk in real time.
- How current mental health services take a dynamic approach to risk management, adapting to manage individuals' fluctuating risk and need.
- Given that The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) is no longer funded to carry out data collection, analysis, and research on patient homicide, there is a requirement at a national level for data that accurately assists with the identification and the likelihood of the risks of particular outcomes.

Local recommendations for the Trust

These recommendations are made with the anticipation that there will be collaboration across the healthcare system to achieve the required change. Whilst these recommendations are directed at the Trust who provided care and treatment for VC, all Trusts need to assure themselves in the following areas.

Area for improvement 3 – Recommendation implementation

We are aware that there have been a number of reviews into Trust services, particularly over the last twelve months and there is considerable pressure on the Trust to improve services whilst delivering care for their population. We have not sought to duplicate recommendations but want to emphasise the importance of the Trust ensuring that implementing recommendations results in positive change to quality and safety.

Recommendation

- The Trust should ensure that they have implemented the recommendations made by other reviews to date, including from the Serious Incident report and the Care Quality Commission. After a period of no longer than nine months from implementation, the Trust should seek to understand whether the changes made have had a positive impact on the quality and safety of care delivery. Views of those with lived experience must be integral to assure the robustness of the Trust's internal assurance process.

Area for improvement 4 – Serious incident policy

We found that the Trust's serious incident policy is not currently in line with the Patient Safety Incident Response Framework (PSIRF). Additionally, there is opportunity for the Trust to better use the outcomes of investigations to identify trends and implement changes to improve patient care and safety.

Recommendation

The Trust needs to ensure that its Patient Safety Incident Response is in line with NHS England's new patient safety framework (PSIRF). Processes should be developed to ensure that subsequent lessons have been embedded in clinical practice and corroborated and supported by people who use the services, their families, carers or support network.

Area for improvement 5 – Family engagement

We found that whilst there were attempts to actively engage VC's family in aspects of his care, there were important milestones when decisions were not discussed with them. We also found that there were opportunities to co-produce aspects of care planning with VC and his family, particularly around safety and scenario planning.

Recommendation

- The Trust should define what positive family engagement looks like. The offer should be developed with people with lived experience – including people who use services, their families, carers or support network, and be informed by all available information. The Trust should then develop processes, in line with national guidance (i.e. the Triangle of Care[22] and the Patient and carer race equality framework[23]), to support effective family engagement. The new

[22] The Triangle of Care (carers.org)
[23] NHS England » Patient and carer race equality framework

processes should inform decisions on care, treatment and the management of both safety and risks.

Area for improvement 6 – Clinical information sharing

We found that there were limitations in the sharing of clinical information across settings which impacted on the ability of those who were caring for VC to fully understand his needs. The current system capability does not allow for the timely sharing of important clinical information between the Trust and independent providers who are placing the Trust's patients in their services. Additionally, the sharing of information with Primary Care to inform important conversation, for example in relation to potential patient discharges, needs to be improved.

Recommendation

- The Trust should develop interoperable systems and processes to enable sharing of necessary clinical and risk-related patient data across clinical care settings. This should include sharing and increasing the visibility of information across primary and secondary care (NHS & independent providers). The purpose of this is to enable shared decision making and risk management with up-to-date information whilst remaining mindful of a person's privacy when identifying necessary information to share.

Area for improvement 7 – Across organisational working

We found that, at times in VC's care and treatment, healthcare professionals were making decisions without a full understanding of information held by all organisations involved with VC. There is the opportunity for system partners to come together to review the arrangements in place for proactively sharing information in a timely manner.

Recommendation

- The Trust, the Integrated Care Board and system partners (for example the Police) should review and evidence the effectiveness and reliability of communication processes across all system partners relevant to mental health care, treatment and risk management.

Area for improvement 8 – Governance arrangements

In this case, we identified that structures and processes of the governance framework at all levels of the local healthcare system, were not set up for identification and communication of potential and existing issues which combined to increase risks to users of the Trust's services and others. We found evidence of siloed governance arrangements and little evidence of triangulation of information to enable system wide learning. We found this to be the case from the Integrated Care Board through to Trust processes.

Recommendation

- The Trust and the Integrated Care Board should seek support from existing expertise in the area of risk and governance within their organisations. This should be used to develop structures, processes and procedures that demonstrate the capability to identify and communicate potential and existing issues and risks. This will require the system to develop the ability to triangulate safety critical information to inform existing and emerging issues. This should be a data driven process drawing from both clinical and operational sources.

Area for improvement 9 – Policy development and review

We found that some Trust policies were out of date and had not been reviewed in a timely way. We also found that there was an acceptance of a drift from policies in day to day practice. In a number of instances, there was not the resource to deliver care in line with the way in which it was prescribed in the policy. There did not appear to be mechanisms to flag the drift from practice and instigate a review of the policy or understand the variation.

Recommendation

- The Trust should ensure that all Trust policies are current, updated and written in a manner that enables staff to practice in line with the policy. Where appropriate, policies should be coproduced with people with relevant lived experience. Policies should include clear guidance for escalation when key deliverables within the policy are not able to be achieved. The Trust should have processes in place to trigger requirements for renewal or review.

Area for improvement 10 – Peer support

In VC's case we found that he may have benefited from being offered peer support within the Early Intervention in Psychosis (EIP) service. We did not find evidence that he was given the opportunity to meet with people who had a shared experience of diagnosis, care or cultural background. We consider there were limited opportunities to try to engage VC in being curious about his diagnosis and how to keep him well.

Recommendation

- As part of the implementation of the community mental health framework, the Trust should ensure that there is a robust peer support offer for those under community mental health services with access to culturally appropriate groups with lived experience. To facilitate a meaningful effective peer support offer, the Trust must consider and have robust mechanisms for recruitment, training, support and supervision and role structure including peer leadership.

Area for improvement 11 – Care planning

We found limited evidence that care planning arrangements were co-produced with VC and his family. Building on area for improvement 5, once the Trust has developed its family engagement offer, arrangements need to be put in place to ensure co-production of care documentation. In VC's case, there was a sense that a shared understanding between clinicians and VC about his diagnosis and factors to keep him well was never fully reached. We did not find evidence that safety planning or scenario planning took place to help support VC and his family.

Recommendation

- The Trust must have processes in place to assure themselves that people who use mental health services, their families, carers and/or support network co-produce care plans. Individuals who use services should be involved in their own personal safety planning arrangements including scenario planning.

Area for improvement 12 – Joint clinical decision making

We observed that inpatient services did not appear to always pay sufficient regard to some potentially important clinical insights and longer-term views provided by the EIP team. The EIP team had longitudinal insights into VC's symptoms and their impact upon his behaviour and his ability to engage with a therapeutic regime. This was most notable regarding the EIP's request for the use of depot medication which was considered and dismissed by the inpatient team. Neither was the use of a Community Treatment Order (CTO) under the mental health legislation considered necessary by the inpatient team. In the right circumstances, a CTO can provide an opportunity for an individual to receive a longer period of inpatient care to enable an enhanced understanding for the individual and the clinical team.

Recommendation

- The Trust needs to ensure that the voice of all of those involved in the care and treatment of an individual is heard and considered within the context of the long-term planning for an individual's care and treatment. Where consensus is not reached about the best plan of action, there needs to be a clear process to escalate views for further consideration. All professionals need to feel empowered to challenge decisions and have the appropriate mechanisms to do so.

8 References

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Appendix I Interviews completed to inform the investigation

Organisation	Number
The NHS Mental Health Trust	
Senior leadership team	5
Inpatient services	5
Crisis team	1
EIP service	6
Primary care	2
Integrated Care Board	4
Independent providers	
Independent provider 1	2
Independent provider 2	1

Appendix II Thematic coding framework to interpret interview findings

Name	Description
1.1 Context	Setting that evidence and information refers to
1.1a Primary care	GP
1.1b Secondary care	Acute inpatient care
1.1c Community care	Delivery of care outside of hospital setting
1.1d Specialist services	Specific funded service - included street triage team and other smaller services as well as independent provider acute beds
1.1e Educational	University
1.1f Employment	Paid role
1.2 Oversight/legislation/guidelines	
1.2a National	National bodies with responsibility to direct and monitor practices, performance and safety for mental health services

Name	Description
1.2b Regional	Regional bodies with responsibility to direct and monitor practices, performance and safety for mental health services
1.2c Local	Local bodies with responsibility to direct and monitor practices, performance and safety for mental health services
1.3 Oversight role/influence	
1.3a Financial	Monitoring and impact on financial spend
1.3b Regulatory	Legal influence on practices and expectations around performance
1.3c Resource provision	Provision of professionals, infrastructure, directed funding
1.3d Clinical risk	Identification and judgment of acceptability in approaches to understand and manage clinical risk
1.3e Person/public risk	Identification and judgment of acceptability in approaches to understand and manage person/public risk
1.3f Governance and assurance	Organisational oversight and structure to enable learning

Name	Description
1.4 Risk control	
1.4a Clinical	Professional responsibility and ability to identify and manage risks associated with clinical condition to self and others
1.4b Organisational operational	Organisations responsibility and ability to identify and manage risks associated with management of patient groups
1.4c Public	Processes and bodies intended to identify and manage risks associated with management of patient groups relative to impact on the wider community - this includes references to the mental health act
2.1 Organisational	
2.1a Policies procedures	Presence, content, availability and suitability of specific organisational documents
2.1b Provision of resources	Process and outcome to ensure sufficiency in resources
2.1c Organisation of resources	Approach to managing, monitoring and distributing resources
2.1d Inter organisational structure	Structures influential to interactions within an organisation and between organisations

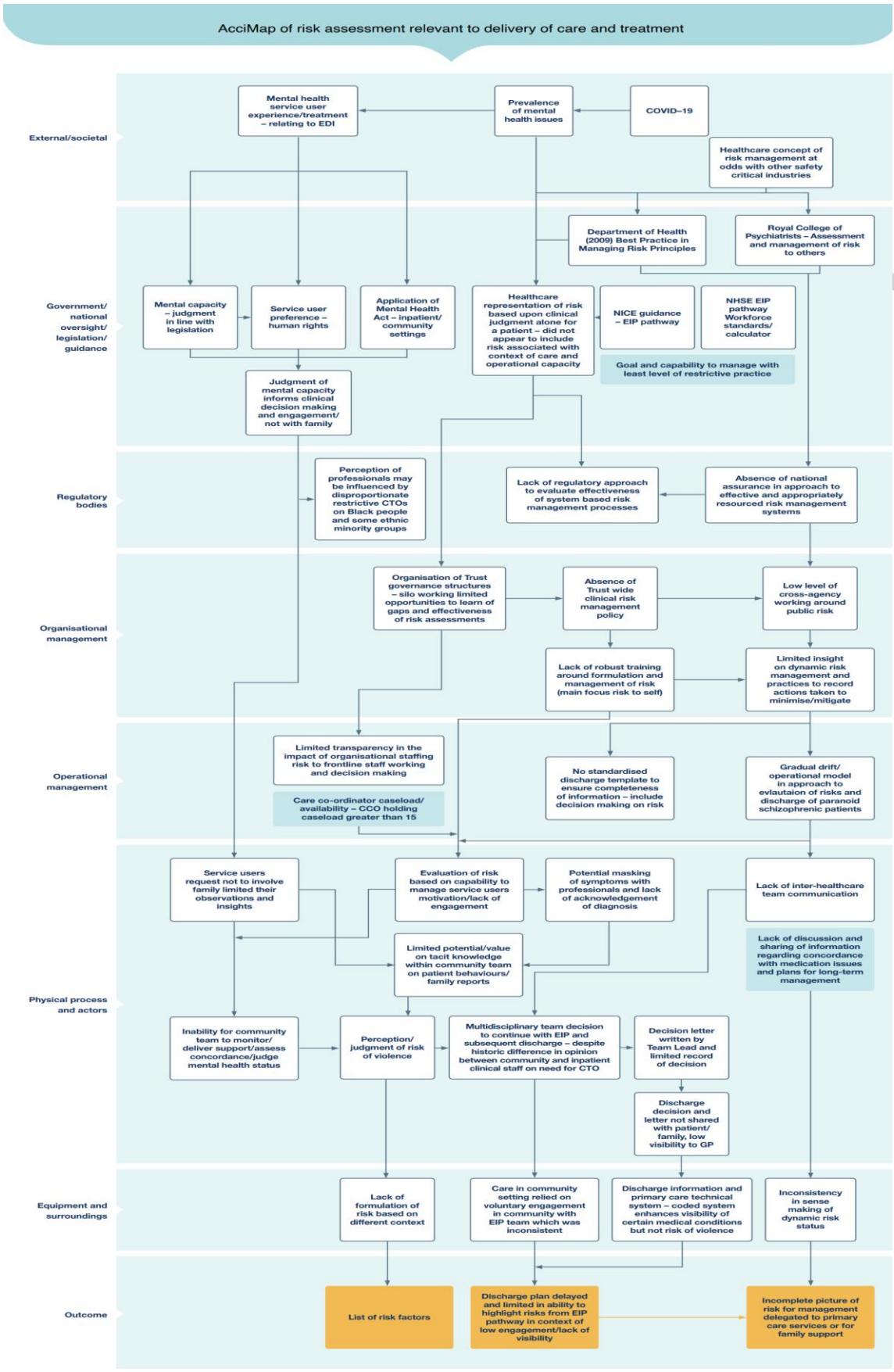
Name	Description
2.2 Tasks	
2.2a Communication	Exchanges through any medium, person, paper or technical
2.2b Information transfer	Transfer of information to share knowledge between people or organisations
2.2c Quality of Information uncertainty/interpretation	Content or presentation of information influential to the confidence or translation of content
2.2d Sense making	Process of assimilating information to develop an understanding and meaning to appreciate potential implications
2.2e Decision making	To consider information, alternative explanations/recognise patterns and make a choice about required action
2.2f Identification/assessment of risk	To recognise and evaluate the likelihood and severity of an unwanted outcome
2.2g Clinical assessment	To consider the signs and symptoms relative to recognised conditions and associated risks
2.2h Deliver treatment/care	To provide relevant interventions e.g., medication, counselling,

Name	Description
2.2i Deliver support	To provide financial, social, personal assistance
2.2j Discharge	To make a decision to terminate one aspect of care
2.2k Monitor – dynamic risk	To maintain an overview of a situation, person or process to recognise signals that imply the need to modify approach to management of risk
2.3 Equipment/Tools	
2.3a Design	Interface, connectivity, support for processes
2.3b Availability	Number or mobility of equipment or tools
2.3c Interoperability	Connectivity e.g. sharing of information or resource across site/context, ability to share information
2.3d Fit for purpose	Meet needs and support tasks
2.3e Access	System enables all stakeholders to use/send information, permissions or set up to enable access
2.3f Operational	Technical system setup to function as expected – working as intended

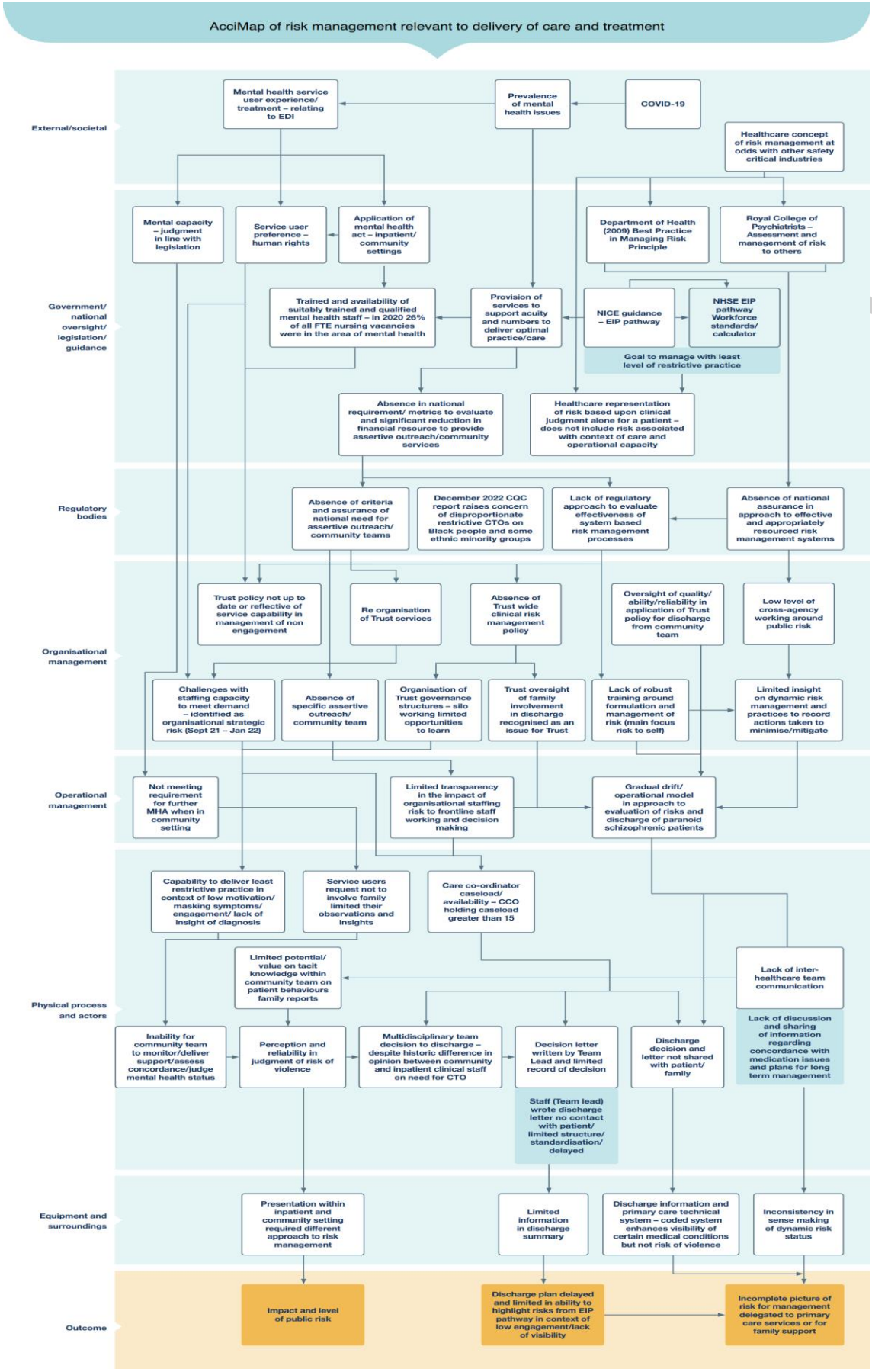
Name	Description
2.4 People	
2.4a Roles	Defined, clarity in responsibility, suitable
2.4b Competence	Relevant experience, knowledge and expertise
2.4c Resource	Sufficient number for work demands, allocated to high demand
2.4d Workload	Achievable work goals to personal/organisational standard
2.4e Person characteristics	Physical, cognitive or personal characteristics influential to outcome e.g., presentation, appearance, stress, emotional response, motivation, personal goals
2.4f Family/carer	Characteristics, perceptions or involvement
2.4g Team	Formal/informal groups of people working with a shared goal to manage and support
2.4h EDI	Related events, information or attitudes that imply inequality or discrimination
2.4i Clinical symptoms	Manifestations recognised as relevant to diagnosis or mental health conditions

Name	Description
2.5 Physical Environment	
2.5a Enviro characteristics	Context specific aspects of an environment or geographical position
2.6 External factors	
2.6a COVID-19	National regulations and additional measures to manage the risk of transmission
2.6b Societal factors	National pressures, motivation and societal attitude.
2.6c Accommodation	Provision, organisation, location

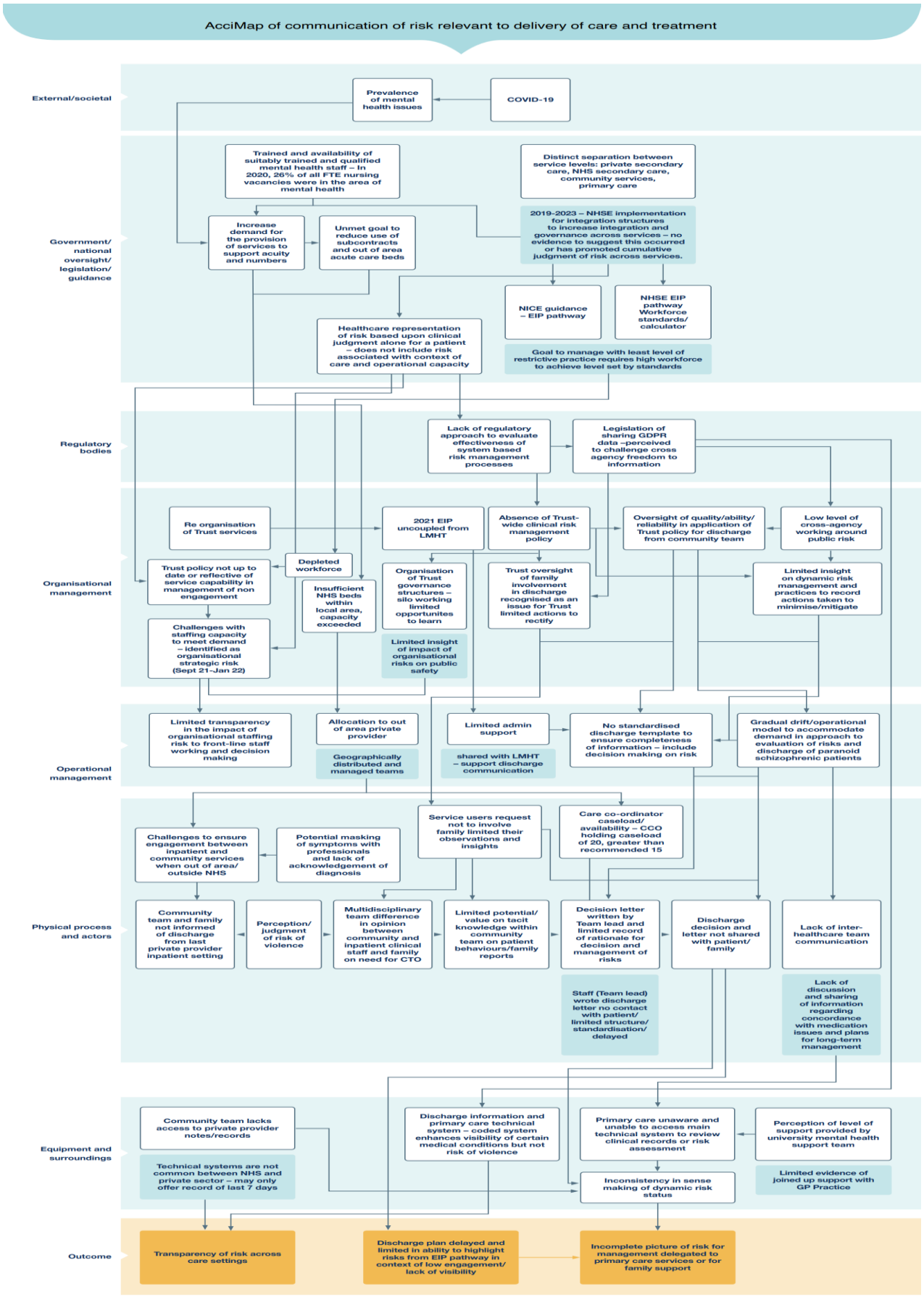
Appendix III Accimap to visualise system interactions influential to **risk assessments** completed



Accimap to visualise system interactions influential to **risk management**



Accimap to visualise system interactions influential to **communication of risk**



Appendix IV Summary of factors influential to implementation of EIP services (O'Connell et al, 2022)

System	Funding	Complexity in commissioning services
		Funding and resource deficits, uncertainty and inconsistency
		EIP threatened by finance diversion to other services
	Services and structures	Strength of existing healthcare system and individual access to services
		Health inequalities
	Political interest	Lack of recognition of EIP value or interest in EIP
		Lack of policy support
Service	Collaboration and communication	Communication with non EIP professionals
		Communication and collaboration with service users and families
	Coherence of EIP program	Strength of definition of EIP program
		Existence and adequacy of provisional implementation guidelines
		Clarity of professional roles and definitions
		Mandating of regular review of treatment progress
		Suite of available and accessible assessments and treatments
		Over ambitious in clinical practice expectations
		Ability to record and acknowledge deviations in implementation guidelines
	Caseloads	Capping of caseloads
		Staff size
		Time spent engaging service users diverting from clinical work
	Referral and discharge	Availability, linkages and communication with GPs and other referrers
		Encouragement of referrers to directly discuss service users with EIP team
		Possibility of self and family referral
		Exit strategy for patients
		Recruitment and retention tied to service funding
	Infrastructure	Virtual locations
		Lack of physical sites
		Infrastructure availability

Staff	Staff attributes	Reluctance to diagnose due to fear of stigma or lack of knowledge
		Willingness to advocate, raise awareness for and reform EIP services
		Skill in safety and risk management
		Collaborative and engagement efforts with patients and families
	Recruitment and retention	Staff turnover, speed of recruitment and appointment

Appendix V Core organisations and bodies within the mental healthcare system relevant to the investigation

Government and legislation	Department of Health and Social Care (DHSC)	Responsible for the oversight and standard required for mental health care through national legislation, standards and strategy whilst ensuring regulatory bodies deliver agreed standards.
Regulators	The Care Quality Commission (CQC)	The CQC regulates mental health services through its monitoring of all health and social care services that carry out regulated activities and by reporting on the use of the Mental Health Act 1983.
	NHS England (NHSE)	Provides oversight of budget, planning, delivery and everyday operations for the commissioning of services by the NHS within England.
National guidelines	NICE	Deliver evidence based guidelines for health and social care services within England to follow specific to a condition or need within a specified context.
	NHS England (NHSE)	Provides guidance to support services provided within England to deliver high quality service through the quality of services, effective governance and provision of resources.
	Department of Health and Social Care (DHSC)	Provides non statutory guidance specific to key areas of delivery of health and social care to promote best practice
Professional bodies	Royal College of Psychiatrists General Medical Council Nursing and Midwifery Council Royal College of General Practitioners	Provide interpretation and information on best practice associated with the delivery of high quality care in line with national legislation and standards. These bodies will reflect in guidance the information required by the professionals they represent to support the role of the professional group in the delivery of mental health care and treatment.

	Royal College of Psychotherapy British Psychological Society Health and Care Professions Council	
Regional bodies	Police	Every region across the UK has a designated police service responsible for the delivery of police services and enforcing criminal law.
	Police, probation and prison services,	These regional services will be brought together to form a Responsible Authority to oversee the Multiagency Public Protection Arrangements (MAPPA) which is a statutory arrangement to assess and manage the risk posed by offenders.
	Social services, department of work and pensions, local housing authorities	These are some of the agencies duty bound to co-operate with the Responsible Authority and ensures engagement of Police, health (NHS Trusts) and social care.
Local	Integrated Care Systems (ICS)	ICS is a local partnership between health and care organisations to develop shared plans and joined-up services. They consist of NHS organisations and local councils and representation from the voluntary sector, social care providers and other partners with a role in improving local health and wellbeing.
	Integrated Care Board (ICB)	An ICB is a statutory body intended to join up health and social care services to improve population health and healthcare, to facilitate equity of care, ensure efficiency and cost effective spending and support social and economic development.
NHS Trust	NHS Foundation Trust	An NHS Trust is a public sector intended to deliver care for a specific geographical area. Trusts are overseen by a board of executive and non executive directors

		reportable to the secretary of state. A Foundation Trust is given greater freedom to run its own organisations as established as 'public benefit corporations'.
Mental Healthcare providers/support	Independent providers	Inpatient mental health services may exceed the capacity within the NHS. In this context the independent sector may offer the only alternative to meet the local area needs.
	Primary care	Is the first point of contact for most people to healthcare services living within a local community. They support the public to manage long term conditions.
	Education-University support	To provide a proactive approach to the wellbeing and mental health of students.

Appendix V Outline role description for experts by lived experience and their biographical statements

Introduction and Context

NHS England appointed Theemis Consulting to undertake a mental health Independent Care and Treatment Review following a very serious incident that resulted in the deaths and serious injury to members of the public in 2023.

NHS England have identified that the purpose of the Independent Investigation is -

- To independently assess the quality of the NHS and partners care and treatment provided against best practice, national guidance and organisational policies.
- To identify opportunities for learning that may be applicable on a local, regional, or national basis.

As part of this process the review team are seeking additional support and insights from experts by experience. The role description below provides an outline of what support is required.

Specific support required

To assist the review team in the review of key findings ensuring that the expertise accumulated through lived experience informs and enhances the outcome of the investigation including its recommendations. This will include-

- Supporting the review of the chronology of the patients contact with Mental Health, Primary Care and any other partners, including private providers, to determine if their healthcare needs and risks were fully understood.
- Help inform the review of the interactions with services, including risk assessment and management plans, in line with Trust Guidance, National Policy and best practice.
- Provide experts by experience insights into the adequacy of risk assessments and risk management processes and what plans were put in place to mitigate those risks.

- Provide advice to the review team whether there were any missed opportunities to engage, listen to and support the patient and his family. This should include any observations regarding culturally appropriate care, treatment and support.
- This role will also include undertaking reading and reviewing relevant material to support the work of the review team.

Biographical Statement

As a racialised individual who has faced severe mental health challenges from a young age, I am deeply committed to ensuring that the lived experiences of people like myself are not overlooked in discussions about mental health systems. For over 25 years +, I have worked tirelessly to rebuild my life after enduring significant mental health struggles during my teenage years. This journey has been one of perseverance and resilience, and I have gained valuable insight into the barriers marginalised communities face in accessing appropriate care and support.

My personal experiences, particularly as an intersectional LGBT+ person, have made me acutely aware of how various social identities can intersect to create unique challenges. I have found that sharing my story and knowledge is a powerful way to contribute to improving mental health systems and ensuring they are more inclusive, responsive, and compassionate.

I chose to get involved in this case because having lived experience at the heart of the process is essential to keeping the focus on the real, human impact of decisions made in this context. I aim to use my insights to ensure that the voices of those who have walked similar paths are heard and that mental health systems evolve better to serve all individuals, particularly those from marginalised backgrounds.

Biographical Statement

I work as the Head of Lived Experience and Coproduction at a Trust where I am supporting the delivery of the Culture of Care programme.

Over the past 10 years I have worked in multiple lived experience roles across the system, including in clinical services, in research and more recently in commissioning. I advocate for peer alternatives, meaningful coproduction and lived experience leadership. Perhaps most importantly, I advocate for compassionate approaches for people who are suffering. I am motivated to create change and help humanise mental health care following my own lived experience of mental health hospitals and iatrogenic harm.