



Liverpool
Clinical Commissioning Group

An independent external quality assurance review following an independent investigation into the care and treatment of a mental health service user (Mr S) in Liverpool

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

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1 Executive summary

- 1.1 NHS England North commissioned Niche Health and Social Care Consulting (Niche) in 2016 to carry out an independent investigation into the care and treatment of a mental health service user S, who received care and treatment from Mersey Care NHS Foundation Trust (previously Mersey Care NHS Trust, called the Trust hereafter). Niche is a consultancy company specialising in patient safety investigations and reviews, the investigation was carried out by Carol Rooney, Deputy Director, Dr Huw Stone, Consultant Forensic Psychiatrist, and Nick Moor, Partner, Niche.
- 1.2 The independent investigation follows the NHS England Serious Incident Framework (March 2015)¹ and Department of Health guidance on Article 2 of the European Convention on Human Rights² and the investigation of serious incidents in mental health services.
- 1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.
- 1.4 The underlying aim is to identify common risks and opportunities to improve patient safety, and make recommendations for organisational and system learning. The independent investigation was carried out in 2016 and made 11 recommendations.
- 1.5 As part of the terms of reference (provided in full at Appendix A) there was an expectation that the Trust action plan would be assessed (within an agreed timeframe) on the implementation of the agreed action plan in conjunction with NHS Liverpool Clinical Commissioning Group (the CCG hereafter) and the Trust.
- 1.6 The expectation was that written feedback of the assessment would be provided to NHS England North, highlighting areas of good practice and measurable improvement or areas of concern. The review was carried out by Carol Rooney, Deputy Director, Niche; Kerry Lloyd, Deputy Chief Nurse, NHS Liverpool CCG; Jan Eccleston, Senior Clinical Quality and Safety Manager, NHS Liverpool CCG and Lyn McGlinchey, Senior Nurse NHS England, (Cheshire and Merseyside)/North, with oversight by Nick Moor, Partner, Niche.
- 1.7 The external quality assurance review commenced in February 2018 and was completed in March 2018, and has focused on the action plan developed by

¹ NHS England Serious Incident Framework March 2015. <https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf>

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

the Trust in conjunction with NHS England and the CCG. The family have been provided with a copy of the final report.

- 1.8 The external quality assurance review comprised interviews with clinical and managerial staff from Mersey Care and a review of documents and policies.
- 1.9 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

Summary of care and treatment

- 1.10 S was diagnosed with paranoid schizophrenia in 1994, after being transferred from prison to the Scott Clinic, which is the inpatient medium secure forensic mental health service run by Mersey Care NHS Foundation Trust in Liverpool. His behaviour was noted to be increasingly bizarre. He spent four months as an inpatient and was treated with antipsychotic medication before returning to prison. There were seven admissions to the Scott Clinic between 1994 and 2003, and S was discharged to the care of the Forensic Integrated Resource Team (FIRT) in 2003. This was the community forensic service which offered aftercare following discharge from the Scott Clinic.
- 1.11 S was admitted to the Scott Clinic in June 1995 under Section 2 of the Mental Health Act 1983 (MHA)³, which was converted to Section 3 MHA,⁴ and he spent less than a month in hospital. His third admission was in August 1995 after assaults on his parents, remaining under Section 3 MHA for four months.
- 1.12 His fourth admission in February 1996 under Section 3 MHA was after he had become increasingly bizarre, and had stabbed his grandmother's dog to death. On this occasion he was treated with depot medication, and was discharged in August 1996 under a supervised discharge order.
- 1.13 S was settled in the community for the following two years, and had three further informal admissions to Scott Clinic. He requested that he stop his depot medication in March 1999 and was admitted after this. At this time there were doubts about his compliance with oral medication, and he had

³ The Mental Health Act 1983 is an Act of parliament which applies to people in England & Wales. It covers the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. <http://www.legislation.gov.uk/ukpga/1983/20>

⁴ Section 3 MHA 1983 Admission for assessment. <http://www.legislation.gov.uk/ukpga/1983/20/section/3>

been using cannabis and alcohol more regularly. He was discharged after three weeks. There was a further informal admission in July 1999, when he asked to be admitted saying he was dangerous, and said he was afraid he would attack his parents. He was discharged in September 1999, and was still subject to the supervised discharge order until August 2000. His last admission was in January 2003, after his mental state appeared to deteriorate. He was discharged after eight days and his Olanzapine⁵ was increased to 30 mg per day.

- 1.14 From 2003 until 2014 S lived in the community with mental health and housing support provided by Imagine⁶ under the care of the FIRT, which in 2015 was called the Forensic Outreach Service (FOS). His diagnosis of paranoid schizophrenia did not change from this time, and he had a complex delusional belief system in which he believed his parents had harmed him as a child. He experienced auditory hallucinations and had a belief that there was a prophecy which would lead to him killing his parents. This was known to services and his parents, and was regularly discussed with him by professionals in his care team.
- 1.15 He lived independently in supported accommodation, and S moved house in November 2013, to a flat also supported by Imagine.
- 1.16 Early on the morning of 19 September 2014, S went to his parents' house and stabbed them to death. He then went to the home of his ex-partner's mother, and saw his ex-partner and his child. He was described as agitated, and told his ex-partner that he had killed his parents, then left to take a bus to the Scott Clinic. She phoned the police.
- 1.17 Police attended the Scott Clinic and S was arrested on suspicion of the homicide of both his parents, and was taken into police custody.
- 1.18 S was assessed under the Mental Health Act 1983 soon after his arrest. He was found to be experiencing a number of psychotic symptoms including auditory hallucinations, ideas of reference, and delusional beliefs that a spaceman had taken over his body.
- 1.19 It was agreed that he be transferred to a high secure hospital, because of the potential risks he may pose to himself and others, and he has remained there.
- 1.20 S pleaded guilty to manslaughter on the grounds of diminished responsibility. On 16 March 2015 at Liverpool Crown Court S was found guilty of manslaughter due to diminished responsibility and detained under Section 37/41⁷ of the Mental Health Act 1983.

⁵ Olanzapine is an antipsychotic medication that affects chemicals in the brain. Olanzapine is used to treat the symptoms of psychotic conditions such as schizophrenia and bipolar disorder (manic depression) in adults. <http://www.drugs.com/mtm/olanzapine.html>

⁶ Imagine is a charity that provides range of housing support. <http://www.imaginementalhealth.org.uk/index.php>

⁷ Powers of courts to order hospital admission or guardianship. (1)Where a person is convicted before the Crown Court of an offence punishable with imprisonment other than an offence the sentence for which is fixed by law. Power of higher courts to restrict discharge from hospital (1)Where a hospital order is made in respect of an offender by the Crown Court, and it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further

- 1.21 The Trust undertook an internal investigation that was reviewed by the investigation team as part of the independent investigation.
- 1.22 The independent investigation outlined the systemic issues that influenced practice in the forensic community team during 2014. While we consider that systems issues influenced practice, there is nevertheless some learning for individual practitioners.
- 1.23 The view was that the homicide of S's parents was not preventable, but a more clinically assertive evidence based model of care might have alerted services to a change in S's condition earlier.
- 1.24 The service concerned was noted to have adopted a much more clinically assertive process to help manage the risks of similar patients in the community.
- 1.25 The independent investigation made 11 recommendations for the Trust to address in order to further improve learning from this event.
- 1.26 An outcome focussed action plan was developed in conjunction with NHSE England, Niche, the CCG and the Trust.
- 1.27 Throughout the management of this incident, NHS Liverpool CCG has worked with the Trust and partners to ensure that the development of the action plan was outcome-focused and considered previous cases. Workshops have been facilitated by both the CCG and NHS England to facilitate greater learning and impact.
- 1.28 NHS Liverpool CCG has an internal governance structure in place which allows for oversight and scrutiny of the action plan at a number of levels. The investigation and action plan was initially reviewed at the Serious Incident panel, attended by a multi-disciplinary team of medical, nursing and managerial personnel. Once deemed 'fit for purpose' by the panel, the action plan is monitored via the monthly Serious Incident meetings held with the CCG and the Trust. Once there is consensus between the Trust and commissioners that actions have been taken and are embedded, the plan will be 'closed down'.
- 1.29 Other mechanisms for assurance have included 'Board to Board' presentation of the investigation and action plan, which for this case, took place at the joint quality meeting. This approach provided further opportunity for scrutiny as to the actions taken to mitigate recurrence.

offences if set at large, that it is necessary for the protection of the public from serious harm so to do, the court may, subject to the provisions of this section, further order that the offender shall be subject to the special restrictions set out in this section; and an order under this section shall be known as "a restriction order".

Assurance follow up

- 1.30 The independent investigation was published in September 2017.
- 1.31 It was agreed that an assurance review of the implementation of the action plan would be carried out within six months of publication. The relevant section of the terms of reference is:

Conduct an assessment (within an agreed timeframe) on the implementation of the agreed action plan in conjunction with Liverpool CCG and Mersey Care NHS Trust and provide written feedback of the assessment to NHS England, North highlighting areas of good practice and measurable improvement or areas of concern.

- 1.32 It is acknowledged that this homicide and subsequent investigations has had far reaching effects on the Trust. The way in which serious incidents are addressed and the subsequent action plans managed has changed markedly. There has been executive team oversight of the detail of the investigation and follow up work, and senior clinicians are directly involved in remedial plans.
- 1.33 The intention of the Trust was that the learning from this tragic event should become embedded in everyday practice. The overall conclusion of this review is this has been successful, and there is robust assurance for many of the actions, showing evidence of embeddedness and of impact in many areas.

	Recommendation	Desired outcome	Grading
1	The formulation of HCR20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR-20 Version 3 Guide.	Patient and team are aware of risks and the plans in place to these mitigate risks. The risk management plans are appropriate and proportionate and reflect current risks.	B
2	The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning. On-going contact with family members or partners must form part of the core risk assessment and care planning by the care co-ordinator	Identified and current potential victims are aware, have been involved and have knowledge of the risks to themselves and what plans are in place to mitigate these risks.	B
3	Where there is a question of responsibility for the welfare of the child, specific focussed risk assessments must be conducted in partnership with children's agencies and other statutory agencies with respect to assessing and managing any potential risk towards the child.	Risks to identified children are known, have been assessed and plans in place to mitigate risks that are reviewed and monitored.	C
4	There should be a robust risk assessment of lone workers in the community, including any pregnant staff and risk management plans applied.	Individual staff can articulate risks and are aware of plans to mitigate risks.	A
5	There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients focusing on both the nature and degree of mental disorder.	Section 12 Doctors and AMHPs have knowledge of and can articulate forensic component of mental health assessment.	C

	Recommendation	Desired outcome	Grading
6	There should be a trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing which should be in line with the Royal College of Psychiatrists guidelines.	Practice in line with Trust policy and NICE guidance, services understand prescribing differences between practitioners and between services.	D
7	An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed.	Establish variation in prescribing practice including routes of administration.	D
8	NHS Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services.	Physical health checks and information is shared between primary and mental health services, clear pathways and processes that are mutually understood.	B
9	The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, with the Secure Division and implement findings.	Patients receive treatment in line with NICE guidance and deviations from guidance are known and monitored and reviewed.	C
10	The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information.	Proactively identify any emerging concerns of safety, quality and performance to ensure actions are taken in a timely manner.	A
11	The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide.	Staff have knowledge and review practice in light of evidence on parricide.	C

2 Assurance review

Approach to the review

- 2.1 The external quality assurance review has focused on the action plan developed by the Trust in September 2017.
- 2.2 The external quality assurance review commenced in February 2018 and was completed in May 2018, and was carried out by:
- Carol Rooney, Deputy Director Niche;
 - Kerry Lloyd, Deputy Chief Nurse, NHS Liverpool CCG;
 - Jan Eccleston, Senior Clinical Quality and Safety Manager, NHS Liverpool CCG and
 - Lyn McGlinchey, Senior Nurse NHS England, (Cheshire and Merseyside) North
- 2.3 This external review was comprised of a review of documentary evidence supplied, and interviews with key clinicians and senior staff from the Trust.
- 2.4 We have graded our findings using the following criteria:

Grade	Criteria
A	Evidence of completeness, embeddedness and impact.
B	Evidence of completeness and embeddedness.
C	Evidence of completeness.
D	Partially complete.
E	Not enough evidence to say complete.

- 2.5 As part of our review we interviewed:
- Head of Nursing & Patient Experience, Secure Division and Specialist LD¹¹ Services
 - Chief Operating Officer, Secure Division
 - Head of Social Work & Nominated Officer for Safeguarding in Forensic Services
 - Director of Patient Safety
 - Forensic Outreach Service Manager
 - Lead Consultant, MSU
 - Enhanced Care Team Lead
 - Associate Medical Director, Secure Division
 - Head of Safeguarding
 - Named Nurse Safeguarding Children
 - FOS team members
 - MSU clinical staff

- 2.6 The original terms of reference are at Appendix A. A full list of all documents we referenced is at Appendix B.
- 2.7 The draft report was shared with NHS England, the Trust, and NHS Liverpool Clinical Commissioning Group. This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Structure of the report

- 2.8 Section 2 describes the process of the review, and Section 3 gives an overview of Mr S's history and mental health treatment.
- 2.9 Section 4 describes in detail the actions planned in response to the recommendations made by the independent investigation, and the progress the Trust has made in making and embedding change.
- 2.10 A summary is at Section 5.

3 Summary of care and treatment of Mr S

- 3.1 Mr S was diagnosed with paranoid schizophrenia in 1994, after being transferred from prison to the Scott Clinic, which is the inpatient secure forensic mental health service run by Mersey Care NHS Foundation Trust in Liverpool. His behaviour was noted to be increasingly bizarre. He spent four months as an inpatient and was treated with antipsychotic medication before returning to prison. There were seven admissions to the Scott Clinic between 1994 and 2003, and S was discharged to the care of the Forensic Integrated Resource Team (FIRT) in 2003. This was the community forensic service which offered aftercare following discharge from the Scott Clinic.
- 3.2 S was admitted to the Scott Clinic in June 1995 under Section 2 of the Mental Health Act 1983 (MHA), which was converted to Section 3 MHA, and he spent less than a month in hospital. His third admission was in August 1995 after assaults on his parents, remaining under Section 3 MHA for four months.
- 3.3 His fourth admission in February 1996 under Section 3 MHA was after he had become increasingly bizarre, and had stabbed his grandmother's dog to death. On this occasion he was treated with depot medication, and was discharged in August 1996 under a supervised discharge order.
- 3.4 S was settled in the community for the following two years, and had three further informal admissions to Scott Clinic. He requested that he stop his depot medication in March 1999 and was admitted after this. At this time there were doubts about his compliance with oral medication, and he had been using cannabis and alcohol more regularly. He was discharged after three weeks. There was a further informal admission in July 1999, when he asked to be admitted saying he was dangerous, and said he was afraid he would attack his parents. He was discharged in September 1999, and was still subject to the supervised discharge order until August 2000. His last admission was in January 2003, after his mental state appeared to deteriorate. He was discharged after eight days and his Olanzapine was increased to 30 mg per day.
- 3.5 From 2003 S lived in the community with mental health and housing support provided by Imagine under the care of the FIRT, which was named the Forensic Outreach Service (FOS) in 2015. His diagnosis of paranoid schizophrenia did not change from this time, and he had a complex delusional belief system in which he believed his parents had harmed him as a child. He experienced auditory hallucinations and had a belief that there was a prophecy which would lead to him killing his parents. This was known to services and his parents, and was regularly discussed with him by professionals in his care team.
- 3.6 He lived independently in supported accommodation, and S moved house in November 2013, to a flat also supported by Imagine. S had care and contact with his child at his own accommodation, several times a week.
- 3.7 S had agreed to abstain from alcohol and cannabis if he was looking after the child. There were times that S had the child to stay for several days.

- 3.8 Early on the morning of 19 September 2014, S went to his parents' house and stabbed them to death. He then went to the home of his ex-partner's mother, and saw his ex-partner and his child. He was described as agitated, and told his ex-partner that he had killed his parents, then left to take a bus to the Scott Clinic. She phoned the police.
- 3.9 Police attended the Scott Clinic and S was arrested on suspicion of the homicide of both his parents, and was taken into police custody.
- 3.10 S was assessed under the Mental Health Act 1983 soon after his arrest. He was found to be experiencing a number of psychotic symptoms including auditory hallucinations, ideas of reference, and delusional beliefs that a spaceman had taken over his body.
- 3.11 It was agreed that he be transferred to a high secure hospital, because of the potential risks he may pose to himself and others, and he has remained there.
- 3.12 S pleaded guilty to manslaughter on the grounds of diminished responsibility. On 16 March 2015 at Liverpool Crown Court S was found guilty of manslaughter due to diminished responsibility and detained under Section 37/41 of the Mental Health Act 1983.
- 3.13 The Trust undertook an internal investigation that was reviewed by the investigation team as part of the independent investigation.
- 3.14 The independent investigation outlined the systemic issues that influenced practice in the forensic community team during 2014. While we consider that systems issues influenced practice, there is nevertheless some learning for individual practitioners.
- 3.15 The view of the independent investigation was that the homicide of S's parents was not preventable, but a more clinically assertive evidence based model of care might have alerted services to a change in S's condition earlier.
- 3.16 The service concerned was noted to have adopted a much more clinically assertive process to help manage the risks of similar patients in the community.
- 3.17 The independent investigation made 11 recommendations for the Trust to address in order to further improve learning from this event.
- 3.18 An outcome focussed action plan was developed in conjunction with NHSE England, Niche, the CCG and the Trust.

4 Action plan progress

HCR-20 risk assessments

Recommendation 1	Grade
The formulation of HCR-20 risk assessments in the secure services should be aligned to best practice principles and there should be a quality assurance structure to audit the quality of risk formulations and management plans and ensure they are in line with HCR-20 Version 3 Guide.	B

4.1 The expected outcomes were:

- Patient and team are aware of risks and the plans in place to mitigate these risks.
- The risk management plans are appropriate and proportionate and reflect current risks

4.2 A new policy for HCR-20 Operational Standards (version 1, undated) was developed. A multidisciplinary task and finish group headed by the Head of High Secure Psychological Services has developed eight operational standards to guide the completion of level 3 risk assessment of violence using the HCR-20. A working group has been established and an away day held, in order to build consensus in identifying priorities. A collaborative approach was used, with 50 contributors, including colleagues from; Learning Disability, Secure and local services. The standards are applicable to all clinical teams within Secure Services across the Trust. The document sets out minimum standards required for the assessment of risk of violence audit management.

4.3 HCR-20 standards have been disseminated to all staff in Psychological Services across all services within Secure and Specialist Learning Disability service Divisions. The standards have been shared with multidisciplinary teams. The standards have also been shared with a lead RC for dissemination to all Responsible Clinicians. These standards have been ratified by respective service Clinical Governance Committees.

4.4 We saw a clinical audit on the quality of HCR-20 for patients under the care of the Forensic Outreach Service dated December 2016. The results of this audit showed that there were quality issues remaining, in that supporting evidence for 'Presence and Relevance of factors' should be clearly stated; formulations should be reviewed to ensure they contain an ordered coherent and meaningful account of risk that is informed by psychological theory; formulations need to ensure they set out detailed and testable predictions about future risk; the formulations should be reviewed to ensure that they allow for planning and prioritising interventions. A draft action plan had been created with a due date of February 2017, and it has been agreed that a further audit will take place, and improved standards would be developed.

4.5 We also saw a report on clinical audit on quality of HCR-20 in the Specialist Learning Disability service (Whalley) dated December 2017. The results were

mostly positive when measured against the standards, but only 8 of the 10 reports had a formulation which told a coherent, ordered and meaningful story in everyday language (80%).

- 4.6 1 of the 10 reports did not have a formulation which told a coherent, ordered and meaningful story in everyday language (10%). Of the 10 reports, 2 of the 10 reports were not supported by psychologically informed theory (20%). There was no associated action plan following this audit.
- 4.7 The policy and procedure for the use of Clinical Risk Assessment Tools policy (SA 10 v4 February 2017) has been updated to include the approach to quality in HCR-20 risk assessments.
- 4.8 A report on the clinic audit on the quality of HCR-20 for patients under the care of the Secure Division and the Specialist Learning Disability Division had been prepared. The Head of High Secure Psychological Services co-ordinated a meeting of the leads of all services involved in the audit to discuss the findings of the audit and develop an action plan. The meeting took place on 21 November 2017.
- 4.9 The action plan from this report included: to disseminate audit findings across all psychological services, review all HCR-20s within the service and provide assurance that a psychologically informed formulation is available, ensure all HCR-20s have future violence scenarios and intervention plans and disseminate HCR-20 standards across all psychological services staff.
- 4.10 We reviewed notes of the Clinical Audit on the Quality of HCR-20 for patients Psychological Services Meeting Thursday 21 December 2017, and the Secure Divisional Psychology Meeting (Medium, Low, Community & Offender Health) Tuesday 7 November 2017 where this was discussed.
- 4.11 We saw a sample tracking document showing the LSU HCR-20 planned review dates for January 2018, and new guidance for supervision discussions; 'staff have been informed that they will be required to have their HCR-20 report reviewed as part of their clinical supervision. The frequency of these discussions will be determined individually for each clinician in discussions with their line managers and clinical supervisors. This will be recorded in the Your Supervision electronic portfolio'.
- 4.12 We met with the Enhanced Care Team Lead for the Secure Division, and heard that six monthly audits are carried out for review and completion of HCR-20s, and a stringent annual quality audit of all HCR-20s is now in place (results are awaited).
- 4.13 'Joint thinking space' has been introduced; psychologists meet regularly with staff; encouraging ward staff to take ownership and be part of the risk assessment and management process, resulting in better 'buy in' from staff over the last two years.
- 4.14 An internal trainer has devised a programme of training and has identified staff who require training for the next twelve months.

- 4.15 Supervision is firmly embedded in the team and strategies are in place to prevent staff from over-investing in particular cases.
- 4.16 Clinical staff from the FOS team told us that there is now a team approach to risk assessment and planning and the psychologist is sited in the team office. Previously psychology had felt very separate. The HCR-20/risk assessments are developed as a team. The office is also the daily meeting place to discuss anything in terms of concerns about risk.
- 4.17 MSU clinical staff whom we interviewed said that the HCR-20 is embedded as part of CPA process every six months, and risk assessments and scenarios are discussed. There is a clear link in with MAPPA process, attending meetings as inpatient staff; and attending Section 117 meeting prior to tribunals to ensure contingency plans are in place. New Section 17 leave risk assessment documentation has been developed (which we did not see), this was on paper, and is now also on the electronic system. Ward staff also valued the 'joint thinking space' with psychology. There is a session one day a week to discuss HCR-20 with the MDT.
- 4.18 We asked if the HCR-20 was shared with the patient, and it was said some parts could be, but as it may contain sensitive third party information, an alternative way of sharing the formulations was being looked at.
- 4.19 It is clear that the actions related to this issue have been followed through, although the impact of the changes are difficult to measure in terms of preventing violence, the outcome intended has been achieved. We have rated this as B.

Victim safety

Recommendation 2	Grade
The planning of victim safety in partnership with individuals concerned, especially where this involves a family member or partner, must form part of the core risk assessment and treatment planning. On-going contact with family members or partners must form part of the core risk assessment and care planning by the care co-ordinator.	B

- 4.20 The expected outcome was:
- Identified and current potential victims are aware, have been involved and have knowledge of the risks to themselves and what plans are in place to mitigate these risks
- 4.21 A new Victim's Rights policy was developed (SD 50 V1 March 2017) as a direct consequence of this recommendation, written by the Head of Social Care & Nominated Officer for Safeguarding in Forensic Services, whom we met to discuss this. Template victim access to information and information sharing letters were produced and are in use. A letter is sent to the police Victim Liaison Officer for victims advising them of updates regarding the patient. The Head of Social Care described how the electronic clinical systems are being updated to flag risks to family, in the current Epex system it is not easy to recognise victims but the PACIS system will have a flag/page to

go through to a victim plan, contacts, risk assessments, what to do in the event of...etc.

- 4.22 RIO will also have clear flags to identify victims and potential victims. The Trust is looking at interoperability across different systems, IT systems do not currently speak to each other well and work is ongoing with IT to look at how to access information when needed; flags in some systems with read only access to some systems, but not there yet. PACIS is in use in the MSU at present, and the Trust is introducing it in other areas in stages. PACIS is for secure services, in house developed, and easy to make changes.
- 4.23 We saw minutes of the Local Division Operational Management Group Meeting for Wednesday 1 November 2017 where the new Victim's Policy was presented by the Head of Social Care & Nominated Officer for Safeguarding in Forensic Services. We saw the Victim's Rights Policy Implementation plan which detailed information sharing expectations, and roles and responsibilities of RCs and Tribunals, including ensuring that victims are informed of tribunals and their views are sought and included. A presentation was prepared in April 2017 informing Trust staff of these new arrangements, and a flow chart for information sharing and decision making was shared.
- 4.24 Processes are in place through support and challenge, team meetings, supervision, training and safeguarding training to raise staff awareness to potential risks to family/carers. It was acknowledged that the previous Forensic community team were isolated but this is not the case now; there is clear governance, oversight and transfer of skills.
- 4.25 The Trust have access to carer/family feedback/suggestions and have completed a 'You said: We did' exercise following the distribution of a carer's questionnaire. The Trust has embraced the Triangle of Care. The Trust provided CQUIN evidence to demonstrate the work completed with Carers in the Secure Division and regionally. Carer's handbooks available across all secure services, forums in place locally and regionally for carers. The carer's toolkit, developed with University of Central Lancashire was launched in March. The Trusts contribution to this was significant.
- 4.26 There is clearly more support for carers now, the 'life rooms'⁸ are used for seminars, the gate lodge in Ashworth is now a carer's centre, and sessions are put on for carers.
- 4.27 Areas of good practice shared across from High Secure to MSU and LSU.
- 4.28 Tours are arranged for carers/relatives as feedback showed people were concerned they never saw the ward or what activities took place on them.

⁸ Mersey Care NHS Foundation Trust has built on the success of the Life Rooms in Walton by opening another venue in Southport as a centre for learning, recovery, health and wellbeing. Just over a year since completing the stunning restoration of the former Walton Library into a community hub and home for the Recovery College, Mersey Care has now transformed the former Living Well centre in Southport. The refurbished building is a base for a range of life opportunities for service users, carers and the wider community challenging stigma and promoting positive mental health and wellbeing. <http://www.liferooms.org/>

- 4.29 Barnardo's 'Think Family' work – the Trust has been recognised and given an award for work with families.
- 4.30 MAPPA plans are reported on a monthly basis against five standards (MAPNAT) and these meetings are seen as an essential element of risk sharing across and between agencies. April 2017 results showed that this was an area that the Trust had focused on improving. We saw MAPPA quality data for April 2017, July to August 2017, and September to December 2017. The latest results showed the Trust was achieving all standards at 100% apart from attendance at MAPPA meetings, although the target of 90% was achieved.
- 4.31 We were told that this is discussed within the HCR-20 process; the importance of involvement of families is recognised and that it is vital for people to understand risk elements. Staff are trained to look for subtle signs of anxiety in families and carers and how to explore tell-tale signs of coercive behaviour in the service user and/or of escalating risk. Awareness is raised in terms of families formulating their own informal risk plans and the need for staff to identify this behaviour. The importance of observing family dynamics during contact visits was stressed and how service users may attempt to avoid community home visits, keeping staff members from observing the home environment, therefore staff would not observe the 'full picture' of family life.
- 4.32 Feedback from meeting FOS team members was that family/carers involvement is identified earlier, so it is not a surprise when the service users are discharged from the inpatient services. Part of the FOS structured monthly meeting agenda is family involvement; planning and recording how the family is contacted, in the form of meetings or regular phone contact. The contact is within the care plan and backed up on Epex. Discussion takes place with families and potential victims, taking their views. Care coordinators will ring periodically and ensure they have the correct contact details for 24 hr contact if required. Some recent positive feedback from family was where a patient had moved to Scotland. Most visits are at the patient's house, and families are there mostly too, and it was stated that the whole approach to families and victim safety planning is very much in the FOS Team's minds.
- 4.33 The FOS team manager has developed an audit of standards based on the action plan, and in this respect included 'Victim safety is central to care practices for community patients'. The December 2017 audit of all 28 FOS patients showed that in all relevant cases there were victim safety plans available, there was ongoing contact with family members or partners included in the core risk assessment, and ongoing contact with family members or partners was included in the care plan.
- 4.34 We did not access any carer feedback on this aspect, but reviewed the Trust Report for the Service User & Carer Strategy Group meeting on 15 June 2017. We saw two short videos entitled 'Forensic Carers Toolkit', which are short films that have been produced in partnership with NHS England and the University of Central Lancashire. Secure division carer leads are included in this film, which describes good practice in forensic mental health. The videos

have been sent to senior management and communications feedback to date (at June 2017) has been very positive.

- 4.35 Secure Division carers have contributed to the development of a Carer's Charter that will be Trust Wide. This is to be launched by the people participation team once this is signed off.
- 4.36 While it is clear that the actions related to this issue have been followed through, although the impact of the changes are difficult to measure in terms of preventing violence, the outcome intended has been achieved, therefore this was rated as B.

Risk to children

Recommendation 3	Grade
Where there is a question of responsibility for the welfare of the child, specific focussed risk assessments must be conducted in partnership with children's agencies and other statutory agencies with respect to assessing and managing any potential risk towards the child.	C

- 4.37 The expected outcome was:
 - Risks to identified children are known, have been assessed and plans in place to mitigate risks that are reviewed and monitored.
- 4.38 We were able to discuss these issues with the Head of Safeguarding and the Named Nurse, Safeguarding Children. We were told that 'Think Family' is the overarching ethos and has been implemented in the Trust. Promoted in training, risk to child, domestic violence, included in supervision, early help and intervention. Stronger messages now in training and supervision and communications. Regular safeguarding audits are completed.
- 4.39 We viewed the Safeguarding Strategy Group Minutes for 6 June 2017 and 8 August 2017.
- 4.40 RiO now includes sections to gather more information and intelligence about family/children. Datix forms are completed for all referrals for safeguarding.
- 4.41 Audits have been undertaken, and there are planned audits to check if people are completing the documentation properly. The current audits cover: Multi Agency Risk Assessment Conference, the voice of the child, Child Sexual Exploitation, early help, neglect, child with disability.
- 4.42 A Training Needs analysis was conducted, and at December 2017 the numbers trained against target across the Trust are as follows:
 - Level 1 safeguarding children and adults 95% completed
 - Level 2 safeguarding children and adults 75% completed
 - Level 3 safeguarding children and adults 94% completed
- 4.43 We saw the training packs for Induction, level 1, 2 and 3 safeguarding training, and the knowledge checks conducted.

- 4.44 The 'Voice of the Child' is included in training and considering 'what would the child in this household tell me'. Encouraging professional curiosity – confidence to 'open the can of worms'.
- 4.45 Safeguarding supervision is accessed via designated nurses, Trust has safeguarding ambassadors who get training and support, proactive offer of supervision when flag on system identify risk factors for children of patients on caseload, supervision policy changed to include safeguarding supervision offer, and prompts on the form encourage staff to seek safeguarding support.
- 4.46 We were told by MSU and FOS staff that if there is a child involved a plan is developed, and there would be a plan for the child to come to clinic before any contact in community, ask for photos, would consult children's services, consider if it is in the best interest of the child before any child contact in the community. A social worker is involved in the first visit to observe and assess. Example given of stopping leave given so assessments can be undertaken; discussed with MDT, and it was noted that the family had not considered contacts with children in wider family.
- 4.47 It is clear that actions related to this issue have been followed through, although the impact of the changes are difficult to measure in terms of preventing violence, there is evidence that the outcome intended has been partly achieved, but not embedded, therefore this was rated at C.

Lone working

Recommendation 4	Grade
There should be a robust risk assessment of lone workers in the community, including any pregnant staff and risk management plans applied.	A

- 4.48 The expected outcome was:
- Individual staff can articulate risks and are aware of plans to mitigate risks.
- 4.49 A protocol and guidance for lone working risk assessment in the FOS was developed and implemented in November 2017. There is clear guidance about risk assessment, communication about location of planned visits, and a protocol for informing the on-call FOS senior meme be of staff of finish time at the end of the day.
- 4.50 There is a safety code phrase that all staff can use if require they require assistance when on a visit.
- 4.51 The FOS manager had audited practice in December 2017 and compliance with all elements of the protocol was found.
- 4.52 FOS staff at our meeting were able to clearly articulate the use of the protocol in practice. We felt strongly that the interviews demonstrated evidence of completeness, embeddedness and impact, particularly from some of the

examples given, however we did think the audit report lacked qualitative information.

4.53 We consider that the outcome intended has been achieved, and we rated this as A.

Section 12 MHA and AMHP training

Recommendation 5	Grade
There should be a programme of training for Section 12 doctors and AMHPs on risk assessment in forensic patients focusing on both the nature and degree of mental disorder.	C

4.54 The expected outcome was:

- Section 12 Doctors and AMHPs have knowledge of and can articulate forensic component of mental health assessment

4.55 The Head of Social Care & Nominated Officer for Safeguarding in Forensic Services has organised social supervisor training in the Trust. A colleague from WLMHT who is known as a national expert (Service Head - Ealing Forensic Mental Health Social Work Service) has been up twice; one training session with forensic service staff, second mixed with local division and CMHT staff. Peer support and peer social supervision is in place for AMHPs in the Trust.

4.56 We saw the lesson plans for the two day social supervisor training which has been held twice in 2017. This included lessons learnt from the Mr S case, and we saw the training register and feedback comments.

4.57 We saw a number of presentations about the case and sharing lessons learned.

- By the Head of Nursing to the CCG Clinical Quality and Performance group at NHS Liverpool CCG in September 2016.
- An Oxford Model Event presented by the consultant forensic psychiatrist who was the lead report author of the internal investigation.
- A joint presentation at the Quality & Safety Forum in January 2016.
- A full day learning event in October 2015 focussing on learning from the Mr S case, with Professor Jenny Shaw, NCISH.

4.58 A summary report was prepared by the Vice-Chair of the National AMHP Leads Network (Social Care Professional Lead, Mersey Care) on the integration the implications of the Mr S case on AMHP practice and lessons learnt within our comprehensive AMHP/Social Work/peer supervision including joint AMHP/Psychiatrists reflective practice forums.

- 4.59 A teaching session for AMHPs and doctors was held in February 2016 with the Lead for Forensic Social Work & Safeguarding and the Forensic Social Care Manager). The session looked at the role of mental health professionals working with the Police, the Criminal Courts, and the Prison Service. We critically examined interventions in acute secure care. We also considered effective risk assessment, rehabilitating and the role of Forensic Community Mental Health services.
- 4.60 In March 2016, a joint session was held with the Head of Nursing & Patient Experience, Secure Division) Serious Case Review and implications to AMHP practice; lessons learnt from Mr S, risk assessment/management and working together in practice.
- 4.61 In January 2017 a joint session with the Personal Safety Advisor looked at therapeutic approaches to working with people whose behaviour is challenging. Implementing effective conflict resolution can be an issue in practice, considering it requires a vast amount of skill and patience. In order to beneficially resolve conflict, constructive strategies must be used in order to avoid misunderstandings or crisis. As social workers, we will indefinitely experience cases involving conflict resolution which will challenge us, however; it is critical to address conflict resolution in a positive, constructive, and meaningful way.
- 4.62 On 9 March and 17 May 2017 a joint legal update with Peter Edwards Law: focussing on Legal update & serious case reviews which includes cases relating to forensic patients, treatment, care and risk assessment
- 4.63 In February 2018 a joint session with a Consultant Psychiatrist focussed on an overview of the Social & Clinical Supervisor Roles. Focus on risk assessment in forensic patients including care pathways, as well as nature and degree of mental disorder. This was based on case scenarios of real patients known to the service. We considered why women enter secure mental healthcare and the most effective ways of working with female service users. We examined how men's mental health relates to offending and consider national and international best practice. We also looked at how learning disability coupled with mental illness might impact on the risk someone poses to themselves and others. We considered throughout the session how to work most effectively with people with personality disorders, and patients from diverse ethnic and cultural backgrounds.
- 4.64 The Section 12 doctor training is managed by Regional 'Approvals Panels' under the auspices of the Royal College of Psychiatrists. We heard anecdotally from the Associate Medical Director that recent training is light for Section 12 doctors, doesn't drill down into cases, is not clinically focussed, but focused on the MHA and relied on the participants as to how the sessions run.
- 4.65 On behalf of the Department of Health, Tees Esk & Wear Valleys NHS Foundation Trust manages the approvals function for all Section 12(2) doctors and Approved Clinicians seeking approval and re-approval, under the amended Mental Health Act 1983, within the North of England. As such the North of England Approvals Panel covers the North East, North West and

Yorkshire regions. This is managed by an Approvals Manager, with a network of Approval Panels across the North of England. The Trust has made attempts to influence the teaching programme.

- 4.66 The initial training and update training is administered centrally, and Mersey Care have no direct influence on content or focus. Records of Section 12 renewal dates are kept by the Trust.
- 4.67 We suggest that NHSE should ensure that the learning from this case in relation to Section 12 and AMHP training is brought to the attention of the national bodies responsible for training.
- 4.68 We consider that actions related to this issue have been followed through, and there is evidence of considerable input to AMHP and social supervisor training. We would like to see a more systematic approach to the training of Section 12 Doctors. Accepting that the Trust does not influence the external training, there is evidence that the outcome intended has been partly achieved.

High dose prescribing

Recommendation 6	Grade
There should be a Trust wide policy on prescribing high dose antipsychotic medication which includes standards for auditing which should be in line with the Royal College of Psychiatrists guidelines.	D

- 4.69 The expected outcome was:
- Practice in line with Trust policy and NICE guidance, services understand prescribing differences between practitioners and between services.
- 4.70 A new guideline was introduced: SD12 - MM11 - High-Dose Antipsychotic Use Guidelines (local guideline) in June 2017.
- 4.71 There is now a register kept of all patients on high dose antipsychotic prescribing. All patients that are identified as high dose in the Secure Division are peer reviewed as a rolling process.
- 4.72 The Secure Division completed an audit in relation to high dose prescribing and monitoring in October 2016, which was fed back to prescribers directly and through the Secure Division NICE and Clinical Audit group. Audit of high dose and combination antipsychotics in Secure and Specialist Learning Disability Divisions has been completed.
- 4.73 Audit and actions required have been shared and discussed at audit and medical meetings, over seen by the Associate Medical Director.
- 4.74 The local re-audits in 2017 were deferred due to a national audit taking place. The Trust participated in the national POMH audit in February 2017:

Prescribing high dose and combined antipsychotics on adult psychiatric wards.

4.75 The standards for audit were:

- The dose of an individual antipsychotic should be within its SPC/BNF limits.
- Individuals receive only one antipsychotic at a time.
- Where high-dose antipsychotics are prescribed, there should be a clear plan for regular clinical review including safety monitoring.

4.76 This was presented to the Trust in December 2017, and an action agreed was that this would be circulated to wards for reflection and learning, the action was not achieved by the target date of December 2017.

4.77 We consider that actions related to this issue have been followed through, and while there is evidence of consideration and a more considered approach to high dose prescribing across the Trust, this action is partially complete.

Depot medication

Recommendation 7	Grade
An audit of the usage of depot medication in the Secure Division should be carried out and anomalies addressed	D

4.78 The expected outcome was:

- Establish variation in prescribing practice including routes of administration

4.79 Ashworth practices of prescribing have been initiated in Scott Clinic. IM use of clozapine is in place, in cases where nasogastric passing requirements can't be used, these are only for rare and life threatening situations. Protocols have been developed for IM injections/Naso gastric recovery plans, based on published evidence.

4.80 Some differences in prescribing practices across services were noted. IM risperidone is very expensive, and Ashworth clinicians have made efforts to reduce its use; with cost versus clinical effectiveness considered. The data is useful and has been sent to consultants for them to look at the prescribing practices in Scott Clinic. Data is reviewed across the division and shared.

4.81 Staff are said to be more aware of thinking about the safety aspects of being on depot medication and on clozapine, balancing the need for compliance with the effectiveness of clozapine.

4.82 The intended outcome was for the Trust to be aware of differences in prescribing practices across the Secure Division, and influence best practice particularly in relation to depot medication.

4.83 There has clearly been Trust-wide leadership and focus on this issue, and the intended outcome per se has been achieved. For the changes to become embedded it would be useful to see an action plan following the audit, and evidence of these changes influencing practice on an ongoing basis, therefore we rated this as D.

Physical Health checks

Recommendation 8	Grade
NHS Liverpool Clinical Commissioning Group and the Trust should ensure that there is a joint approach to physical health checks, and information sharing between GPs & mental health services.	B

4.84 The expected outcome was:

- Physical health checks and information is shared between primary and mental health services, clear pathways and processes that are mutually understood.

4.85 The FOS has a healthcare support worker whose role it is to monitor and flag physical health check requirements. An audit of physical health check in the FOS in December 2017 had been completed, with actions to be carried out, rated amber.

4.86 There was evidence of assessments, and of letters to GPs with outcomes. It would be useful to have more information from Epex showing what is recorded for physical health checks.

4.87 CCG CQUIN regular reporting and monitoring is in place. CQUIN has been achieved for 2016/17. Further improvement of physical health pathways and communication is included in 2017/18.

4.88 CQUIN programme which will continued to be monitored on quarterly basis

4.89 Trust CQUIN performance data is submitted quarterly and is green as of Q3.

4.90 There has clearly been Trust-wide leadership and focus on this issue, and the intended outcome per se has been achieved.

4.91 For the changes to become embedded it would be useful to see these changes influencing practice on an ongoing basis.

4.92 There is evidence of progression on recording and monitoring, and of information sharing with primary care, we have rated this as B.

NICE guideline compliance

Recommendation 9	Grade
The Trust should audit compliance with NICE guidelines CG178: Psychosis and schizophrenia in adults: prevention and management, with the Secure Division and implement findings.	C

- 4.93 The expected outcome was:
- Patients receive treatment in line with NICE guidance and deviations from guidance are known and monitored and reviewed.
- 4.94 NICE guidance for schizophrenia audit has been completed.
- 4.95 Good progress, audits well organised, 100% response rate.
- 4.96 The national audit was carried out, national audit completed then rerun internally. No lack of engagement. Will link to risperidone v clozapine review/piece of work. Update June 2017:
- 4.97 Trust wide audit was carried out looking at access to therapies and prescribing practices using NICE guidance. Due to report October 2017.
- 4.98 There is evidence of progression on implementing and auditing against NICE guidance, which it is expected would be incorporated into ongoing practice.

Quality structures

Recommendation 10	Grade
The Trust should provide quality performance information on services that consistently appear in the top five or other agreed quantity of quality indicators for two or more quality indicators to systematise the triangulation of performance information	A

- 4.99 The expected outcome was:
- Proactively identify any emerging concerns of safety, quality and performance to ensure actions are taken in a timely manner
- 4.100 In April 2016 the Executive Director of Nursing submitted a paper for approval to the Quality Assurance Committee outlining the annual review of the framework for the governance of quality. The purpose of this paper was to seek the support of the Quality Assurance Committee of a refresh of the Framework for Quality and the support of a new standard operation procedure to accommodate the acquisition of Calderstones NHS Foundation Trust.
- 4.101 In summary the key issues identified in the paper were:
- Introduction of a structured presentation of data based on the STEEP model (Safe, Timely, Effective, Efficient, Equitable, Person Centred) with the added CQC fundamental standard of “Well Led”.
 - An automated system will be developed for the analysis and presentation of data.
 - Surveillance meetings will reduce from three times a week to twice a week with divisional surveillance meetings working to a standardised terms of reference

- A refreshed criteria for referral to “Stand-up Thursday” meetings

4.102 The Trust commissioned an external review of the weekly surveillance structures which concluded in December 2016. This found that the Trust had **Significant Assurance** from its quality and governance processes and noted:

“In summary, all three divisions have embraced the refreshed framework for the quality of governance and are able to demonstrate compliance with the STEEP, well led model albeit using a different approach and methodologies.”

And:

“The secure division has, partly as a result of its client group, a track record of structured governance and surveillance processes that ensure compliance with the Trust’s approach to quality governance.”

4.103 Surveillance meetings are held weekly, and the Trust and divisions now monitor **all** services for changes in quality indicators (no longer just the top three or five services for issues with quality performance). The surveillance meetings receive a standard templated report outlining progress and performance across a range of quality indicators.

4.104 These quality metrics discussed in Surveillance Meetings are linked to the five CQC domains (Safe, Effective, Caring, patient Experience and Well Led) and include:

- Incidents (including violence, safeguarding and AWOL)
- CQC/ MHA monitoring
- HR issues
- Complaints
- Soft intelligence

4.105 This information is triangulated to enable a 360 degree view of the retrospective and prospective issues which may affect a services quality.

4.106 There was evidence of routine (weekly) quality performance monitoring, through surveillance and ‘Stand-up Thursday’ meetings and evidence of actions arising to improve quality.

4.107 These actions have led to genuine and embedded changes to the quality of services.

Parricide risk assessment

Recommendation 11	Grade
The Trust should ensure that care plans for patients with schizophrenia who are assessed as at risk of harming family members incorporate learning from the evidence on parricide.	C

4.108 The expected outcome was:

- Staff have knowledge and review practice in light of evidence on parricide
- 4.109 The Trust has invested in a series of learning and information sharing events related to this aspect since the report was finalised.
- 4.110 Actions have been agreed to enhance staff training and induction programmes within teams.
- 4.111 A 'quality practice alert' was circulated in 27 September 2017 outlining learning points about parricide, and this was disseminated through service and local team meetings.
- 4.112 The victim safety planning elements of care planning as discussed earlier have incorporated this risk awareness. However it would have been useful to see an audit of relevant care plans that have incorporated this learning.

5 Summary

- 5.1 Part of the feedback from the Trust subsequent to this investigation has been that better learning has been distilled from this process by focussing on systems rather than on individuals.
- 5.2 There have been clear efforts to ensure that there is senior level involvement, oversight and support in making the recommended changes, and the effects of this are that there is robust evidence and some good assurance that systems changes are in place in some areas, and in progress in others.
- 5.3 NHS Liverpool CCG has a robust mechanism in place to track actions developed as a result of this investigation. Quarterly action plan monitoring visits take place to monitor progress and there will be a focus on the areas graded as C and D (as described above).
- 5.4 The CCG incident management system (Datix) is used to track the progress of the actions based on expected completion dates. Progress against completion of this action plan will be monitored using the incident management system and any issues or delays will be highlighted to Mersey Care and also through to the CCG Serious Incident Panel.
- 5.5 Any concerns would be addressed through quality and/or contract monitoring arrangements in place between the CCG and Mersey Care.

Appendix A – Terms of reference

Core terms of reference

The Terms of Reference for independent investigation 2014/30776 are set by NHS England, North, in consultation with Liverpool CCG. These terms of reference will be developed further in consultation with the successful offeror of the independent investigation and family members.

Review Mersey Care NHS Trusts internal investigation of the incident to include timeliness and methodology to identify if:

- the internal investigation satisfied the terms of reference
- all key issues and lessons were identified
- recommendations are appropriate and outcome focussed
- the Trust can evidence implementation of the internal action plan and improved outcomes
- affected families were appropriately engaged with

Review the care, treatment and services provided by the NHS and other relevant agencies from the service user's first contact with services to the time of the offence. Including specific reference to the review of:

- the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern
- the adequacy of risk assessments and risk management, including specifically the risk of the service users harming themselves or others
- the effectiveness of the service user's care plan including the involvement of the service user and the family
- compliance with local policies, national guidance and relevant statutory obligations

- the adequacy of risk assessments and risk management, including the risk of the service users harming themselves or others

Based on overall investigative findings, constructively review any gaps in inter-agency working and identify potential opportunities for improvement.

Involve the affected families as fully as considered appropriate, in liaison with Victim Support, police and other support organisations.

Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement.

Provide a written report to NHS England North that includes outcome focussed measurable recommendations.

Assist NHS England, North in undertaking a brief post investigation evaluation.

In July 2015 a joint commissioner and provider workshop was held to consider this specific case and previous incidents of homicide involving service users of the Scott Clinic (secure services). The workshop provided an opportunity to collectively review the relevant investigation reports and identify any common service delivery problems, care delivery problems, contributory factors or root causes. The review process resulted in the identification of a number of common themes. Each theme was considered by the group in terms of its significance and impact and through collective agreement a number of key themes were identified for further analysis. To review the Governance arrangements for the three divisions within Mersey Care: the local division, acute services and secure division which brings together high, medium and low secure and community services ensuring consistent approaches are applied across the Trust.

Examine the identified key themes from this and previous homicides involving service users of the Scott Clinic. Provide a written report with recommendations on the quality and governance processes (including organisational culture and leadership) in the following identified services/areas within the Scott Clinic and where appropriate, across Mersey Care NHS

Trust:

- Dual Diagnosis Service – interface with the Scott Clinic
- Carer involvement – including availability of information resources, engagement with and sharing of information, the protection of carers and the potential barriers of consent and confidentiality
- Medication Issues - including compliance testing and use of the Mental Health Act
- Risk assessment - focussing on the known and evolving risks, planning for reduction and mitigation of risk, sharing of information in relation to risk
- Pathways of care for service users with a diagnosis of paranoid schizophrenia, including:

- treatment of condition
- access to psychological interventions
- care co-ordination
- engagement both with and between patients and carers
- communication between the Trust and primary care services

Where partially implemented recommendations from previous homicides are identified determine if there are organisational barriers to full delivery

Support Mersey Care NHS Trust to develop a comprehensive outcome focussed action plan based on both the investigation and reviews findings and recommendations including identifying potential organisational barriers to delivery.

Support Liverpool CCG to develop a structured plan to review implementation of the action plan including the identification and evidence of measurable change.

Conduct an assessment (within an agreed timeframe) on the implementation of the agreed action plan in conjunction with Liverpool CCG and Mersey Care NHS Trust and provide written feedback of the assessment to NHS England, North highlighting areas of good practice and measurable improvement or areas of concern.

Appendix B – Documents reviewed

Mersey Care NHS Foundation Trust documents

Recommendation 1

- HCR-20 Operational Standards Policy v1 2017
- Clinical Audit on the quality of HCR-20 for patients under the care of the Forensic Outreach Service December 2016
- Clinical Audit On The Quality of HCR-20 for patients under the care of Whalley October 2017
- Report on clinical audit on quality of HCR-20 in plans of the HCR-20 is undertaken within the Secure and the Specialist LD October 2017
- Use of clinical risk assessment tools policy SA 2017 v4
- Clinical Audit on the Quality of HCR-20 for patients Psychological Services Meeting Thursday 21st December 2017
- Secure Divisional Psychology Meeting (Medium, Low, Community & Offender Health) Tuesday 7th November 2017

Recommendation 2

- Code of Practice for Victims of Crime, Ministry of Justice October 2015
- Victims' Rights policy SD 50 March 2017
- Victims' Rights Policy Implementation plan
- Practice guidance on procedures concerning representations from victims in the First Tier Tribunal (Mental Health). Tribunals Judiciary, July 2011
- MAAPA QAC data September- October 2017
- MAAPA QAC data July- August 2017
- MAAPA QAC data January – April 2017
- FOS audit service users December 2017

Recommendation 3

- QRV safeguarding response data
- MCT safeguarding assessment RiO screenshot
- LSCB training needs analysis

- Safeguarding Training Personal Beliefs sample
- Safeguarding and protection of children policy SD 13 July 2017
- Safeguarding Strategy Group Minutes 6 June 2017
- Safeguarding Strategy Group Minutes 8 August 2017
- Epex wording and screenshots
- Training roll-out for Child Safeguarding showing quality checks against improved knowledge and application to practice for all front-line staff

Recommendation 4

- Lone worker policy and procedure SD03 December 2015
- Generic lone worker risk assessment December 2017
- Lone worker PROCESS – FOS – NOV 2017
- FOS - LONE WORKER AUDIT - December 2017

Recommendation 5

- Revised policy
- Indicative content of 2 day Social Supervision course
- Training lesson plans/material for social supervisors and AMHPs
- Evidence of training attendance by S/W and doctors

Recommendation 6

- New policy M11 High Dose Antipsychotic prescribing (HDAP) June 2017
- Audit results & any actions agreed/taken
- Secure Division & SPLD audit of high dose prescribing and monitoring in October 2016.
- National POMH audit in February 2017, flowchart & process
- POMH/RCP ready reckoner HDAP
- CGC minutes extracts: CGC 3.12.15, 7.7.17, 6.10.17 and 3.3.16, where the High Dose Audit report was received and noted.

Recommendation 7

- Audit of high dose and combination antipsychotics in the Secure and Specialist Learning Disability Divisions (October 2016)
- HIGH DOSE & COMBINATION ANTI-PSYCHOTICS & BENZODIAZEPINE CASES- medical CPD sessions planned JANUARY 2017 – DECEMBER 2017

Recommendation 8

- FOS audit of health checks December 2017

Recommendation 9

- Internal Clinical Audit On Psychosis (Secure Division only)
- Timeline for Clinical Audit NICE Clinical Guideline 178 - Psychosis and schizophrenia in adults - September 2017 up to March 2018.

Recommendation 10

- MIAA Weekly Surveillance Monitoring Review Mersey Care NHS Foundation Trust December 2016

Recommendation 11

- FCS 01- policy & procedures for the management of service users under the care of the Forensic Outreach Service, June 2016.
- TB Independent investigation Feedback Session 4 November 2016
- OXFORD MODEL EVENT 'Learning from Recent Homicide Investigation' 30 October 2015, agenda & attendees
- QPA Alert 201-34 - September 2017 Awareness and Management of Risk of Parricide (the killing of one or both parents)