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HEALTH & SOCIAL CARE CONSULTING

WEST CUMBRIA
COMMUNITY SAFETY PARTNERSHIP

Joint Domestic Homicide Review and independent mental health homicide investigation in January 2019, West Cumbria

May 2022

First published: **May 2022**

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Our Report has been written in line with the terms set out in the Terms of Reference for the independent investigation into the care and treatment of a 45-year-old man in West Cumbria. This is a limited scope review and has been drafted for the purposes as set out in those Terms of Reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date.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

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Preface

This Joint Domestic Homicide Review (DHR) and Mental Health Independent Homicide Investigation was carried out following the death of Annie. We wish at the outset to express our deepest sympathy to the family of Annie.

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

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

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

This has been the third statutory homicide review carried out in West Cumbria.

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

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

Contents

1. Introduction

1.1 This review is about the homicide of Annie, and the perpetrator of the homicide, her son Mr M. In January 2019 North West Ambulance Service (NWAS) received a 999 call. The caller (Mr M) said "I've just killed my mother". The call taker attempted to ask for more information, but he kept hanging up. Police were alerted and an ambulance crew were dispatched immediately to his parents' house in Dearham, Cumbria.

1.2 The ambulance first responder arrived at the address to be met by Mr M who said he was responsible. As the responder returned to her vehicle to collect her equipment, the police arrived at the scene.

1.3 Annie was found in cardiac arrest with multiple stab wounds. The air ambulance arrived with a doctor on board and resuscitation was unsuccessful, with death pronounced at the scene.

1.4 Mr M was arrested at the scene and taken into custody where he received a mental health assessment. He was later transferred to a secure mental health hospital. He admitted a charge of manslaughter by diminished responsibility and was sentenced at Preston Crown Court in July 2019. He was sentenced to life imprisonment with a minimum of 11 years and made the subject of a hospital order under Section 45A of the Mental Health Act (MHA).[1]

1.5 Mr M had a long history of paranoid schizophrenia, harmful use of amphetamine and cannabis, and dependency on stimulants (amphetamine).

1.6 He had a history of offending, including being cautioned as a juvenile for theft and handling stolen goods. He was also convicted of armed robbery in 1996 for which he was placed on Section 37/41 MHA[2]. An absolute discharge from detention under the MHA was granted by the Ministry of Justice (MoJ) in 2003.[3]

1.7 He had a further conviction in February 2008 for wounding with intent to do Grievous Bodily Harm and received a second Section 37/41 MHA order. He had attempted to attack the victim (a female friend of his brother's) in the garden. Mr M had put a kitchen knife in his bag with the intention of stabbing her with it. He was conditionally discharged by a Tribunal[4] in February 2009 and received an absolute discharge in June 2012. He remained under the

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[1] *Section 45 (A) Mental Health Act 1983, Power of higher courts to direct hospital admission: 'a direction that, instead of being removed to and detained in a prison, the offender be removed to and detained in such hospital as may be specified in the direction'.* http://www.legislation.gov.uk/ukpga/1983/20/section/45A

[2] *Section 37 Mental Health Act (1983). Powers of courts to order hospital admission or guardianship.* http://www.legislation.gov.uk/ukpga/1983/20/section/37.
Section 41 restriction on discharge. http://www.legislation.gov.uk/ukpga/1983/20/section/41

[3] *Ministry of Justice Mental Health Unit manages the 'Mentally disordered offenders: the restricted patient system'.* https://www.gov.uk/government/publications/mentally-disordered-offenders-the-restricted-patient-system

4 First-tier Tribunal (Mental Health) are responsible for handling applications for the discharge of patients detained in psychiatric hospitals
First-tier Tribunal (Mental Health) - GOV.UK (www.gov.uk)

care of mental health services during these periods in both hospital and in the community.

1.8 His engagement with community mental health services was variable, he had not been seen regularly or taken his prescribed medication since August 2018.

1.9 The principal people referred to in this report are:

Person	Role	Relationship	Ethnicity
Annie (69 years old)	Victim	Mother of Mr M	White British
Mr M (45 years old)	Perpetrator	Son of Annie	White British
Daniel	Son of Annie	Brother of Mr M	White British
Len	Husband of Annie	Father of Mr M	White British

1.10 This joint review examines the circumstances surrounding the death of Annie, a 69-year-old female resident of Dearham, Cumbria. Annie was killed by her 45-year-old son Mr M, in her own home in late January 2019. The joint review includes a review of the care and treatment of Mr M by NHS services. The joint review is intended to meet the expectations of both the DHR and NHS England independent investigation. The family have requested that Annie's own name be used rather than a pseudonym, because they want her to be recognised in this review. They have also requested that the names of her husband Len and son Daniel should be included.

1.11 This review will examine agency responses and support given to Annie and her son. It will also examine the past to identify any relevant background, and/or trail of abuse before her death. It will look at whether support was accessed within the community and whether there were any barriers to accessing such support. By taking a holistic approach the review seeks to identify the appropriate solutions to make the future safer for others.

1.12 This report focusses on Mr M 's contact with agencies between his absolute discharge in 2012, with a detailed focus on the period from March 2018 when he was last admitted to a mental health hospital. We will review whether there were opportunities for agencies to have predicted and prevented the incident that occurred based on their knowledge of Mr M. As far as the panel can ascertain, there was no history of domestic abuse or violence by Mr M towards Annie.

1.13 The key purpose for undertaking a Domestic Homicide Review (DHR) is to enable lessons to be learned.[5] In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in any homicide, and most importantly, what

5 Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf*

needs to change in order to reduce the risk of such tragedies happening in the future.

1.14 This joint review has taken place alongside a criminal investigation which followed Mr M 's arrest and subsequently his charge for the murder of Annie. This resulted in an admission of a charge of manslaughter by diminished responsibility in July 2019, after the court was provided with psychiatric reports.

1.15 This report concentrates upon the focus of DHRs, i.e. the relationship between the individuals. It seeks to establish whether domestic abuse was a feature of that relationship and if it was, to find that trail of abuse. Moreover, it seeks to look at what can be learned and what changes can be made to better protect others in the future. It will look to make recommendations that are cross-agency or where it is clear that a different approach may better protect others.

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

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

Events leading up to the homicide

1.18 In January 2019 in the early hours of the morning Mr M was walking his dog down a country lane and was stopped by the police and spoken to. No 'immediate safeguarding concerns' were raised by the police, but they were concerned due to the dark surroundings that he may not be seen by traffic on the road to Dearham.

1.19 Mr M said he was struggling with his mental health and was going to see his parents. The officers dropped him off at Dearham near his parent's house. The police officers did not make any contact with his parents.

1.20 Mr M got no reply at his parent's address, so he walked to his brother's address nearby.

1.21 He knocked on the door of his brother Daniel's house at about 3.00 am, asking if their parents were at home. Daniel did not let him in but said they

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

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

were at home, and later spoke to his father on the phone to let them know Mr M was in Dearham. Mr M went to his parent's house and his Dad (Len) let him in and they stayed up talking for hours. Annie was away on a shopping trip that night.

1.22 Later on that day Len went to the offices of the Allerdale community mental health assessment and recovery team (CMHART).[8] Len asked to speak to a staff member because he was worried about Mr M 's mental health and said Mr M was not sleeping. Len asked for Mr M to be seen for a review and to have some medication. An appointment was arranged for the following day.

1.23 Mr M and Len attended the appointment on 16 January 2019, and saw the duty worker, a registered Learning Disability Nurse (SN1).[9] Mr M was anxious and said he could not have attended on his own, he said he was hearing voices and having hallucinations, and not sleeping. He said he had not been taking his psychiatric medication and had been taking drugs up until Christmas. Len asked for him to be given some medication, and the staff member discussed this with the Specialty Doctor (Dr L) who was reluctant to prescribe medication because he had not had it since August 2018. An appointment with a doctor for a medication review was arranged for 24 January 2019. Mr M said he would stay with his parents until he could get his medication sorted out.

1.24 In the third week of January 2019 Len and Annie had been for a hospital appointment for Len's health. Mr M asked to go to his flat in Workington to collect some clothing and Len took him. On the way home they stopped at some shops for tobacco and groceries. Mr M spent much of the day in his room and told his Dad he was 'not too bad'.

1.25 On the day of the homicide Len went out early to his joinery job. Mr M was seen at a local shop at 8.15 am buying tobacco. The homicide occurred later that morning.

Findings and recommendations

1.26 We have made the following findings and recommendations so that services and systems must learn lessons to improve practice, to ensure that such events do not recur.

Findings

Finding 1 - GP/North Cumbria CCG/NWAS

While the GP surgery provided support and treatment in times of stress, there were missed opportunities to explore whether Annie required support as a carer or had any concerns about her own safety. No routine enquiries about domestic abuse were made, and no referral for a carer's assessment was made.

[8] *CMHART was provided by Cumbria Partnership NHS Foundation Trust, and is now provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.*

[9] *A glossary of professional roles is at Appendix F.*

The GP practice did not have policies in place to support enquiries about domestic abuse or offer any risk assessment tools.

The approach of NWAS emergency teams was within expected practice.

Finding 2 - Cumbria Constabulary

Information about risk which had been logged by police was not conveyed to mental health services in sufficient detail.

There was no routine enquiry about the safety of Mr M 's parents after incidents in March 2018, when his mother had removed knives. The notes record that he had been given them back because his parents did not feel able to refuse, however the family state that this was not how they viewed it.

Risks concerns following the incidents of 19/20 September 2018 were not conveyed in appropriate detail.

Police did not activate the Multi-Agency Risk Evaluation (MARE) process in September 2018.

There was a lack of detail and continuity in the police approach to communicating with other agencies about Mr M , given their awareness of his mental health issues.

Finding 3 - Cumbria County Council and Unity

Cumbria County Council and Unity inputs were within expected policy and procedure.

Finding 4 - North Cumbria CCG/GP

The GP dealt with physical health issues, e.g. smoking cessation advice. Mental health concerns were dealt with completely by secondary care.

There was no communication between Mr M 's GP practice and his mother's GP practice, which is within normal expectations.

Mr M 's GP had very little communication from mental health services in 2018.

Finding 5 - Trust care and treatment

The CPA policy was not followed with respect to care coordinator provision, care planning and reviews, and Trust systems did not identify or address these deviations from expected policy within CMHART.

Assistant Practitioners were assigned to take on the role of care coordinators within the original Trust. We have not made a recommendation that this should stop, because the new Trust has confirmed that this is no longer accepted practice.

There was no care coordinator cover provided for a six-month period in 2018.

There is no evidence of an evidence-based treatment plan that was in line with National Institute for Health and Clinical Excellence (NICE) guidance for treatment of psychosis and schizophrenia in adults: prevention and management.

Finding 6 - Trust medication management

The administration of depot medication was not recorded in the electronic clinical records.

Depot medication was missed, and there was no robust system for ensuring these were administered at the correct times or following up missed injections. This resulted in Mr M being unmedicated from August 2018 to January 2019.

Mr M was not stabilised on depot medication before discharge from Yewdale ward, West Cumberland Hospital.

Finding 7 - Trust inpatient management

Yewdale ward held the belief that Mr M 's admission was as a result of his substance misuse and that once he had detoxified his mental health issues would resolve themselves.

Yewdale ward did not manage Mr M 's admission in line with the Transfer and Discharge of Patients within and from Community Hospital/Step-up Step-Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust.

There was lack of continuity in care planning, admission, and discharge between Yewdale ward and CMHART. There was no liaison between the ward, CMHART or his family to plan and agree Mr M 's discharge plan.

There was poor communication between the ward and CMHART following discharge.

Risk management on Yewdale ward did not take risk assessment into consideration, and leave was unplanned and unstructured, lacking curiosity about his social and family circumstances. This resulted in minimal time actually spent on the ward, which did not allow time for the treating team to get to know him or make contact with his family and assess the situation.

Yewdale ward had no admission and discharge policy at the time.

Finding 8 - Trust family involvement

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

The family was not involved in care planning for Mr M, despite their requests to be involved and informed.

There were no carer's assessments requested or arranged for his parents, despite them specifically requesting this.

Risk management considerations were not applied to his family.

Finding 9 – Safeguarding

There is no evidence to suggest that Mr M or Annie should have been considered as an adult at risk in accordance with the Care Act 2014.

We conclude that there were no missed opportunities in relation to adult safeguarding. However we acknowledge that the family felt that Mr M was a risk to them, and describe how they tried to manage this within the family.

Finding 10 - Trust risk assessment

Mr M 's risk assessments were not updated as expected by the Clinical Risk Policy and did not reflect current risks.

Despite Cumbria Partnership NHS Foundation Trust (CPFT) being warned of concerns about the use of GRiST[10] by its own senior clinical staff and in a recent DHR report, there does not appear to have been any plan to change the risk assessment tool, until the recent merger with Cumbria Northumberland, Tyne and Wear NHS Foundation Trust (CNTW). Action to address this is now in progress.

Finding 11 - Medical reviews

The system for allocation of medical reviews was reactive and not fit for purpose, and waiting lists were lengthy and unmanaged. This resulted in a lack of medical oversight of Mr M's care for 18 months.

CMHART had limited access to medical support and the waiting list for medical reviews was not managed in line with the Standard Operating Procedure.

Finding 12 - CMHART management

Serious concerns had been raised internally about the provision of a quality service by Allerdale CMHART.

We have been made aware of high caseloads, high sickness and turnover of senior staff, inadequate supervision, lack of CPA reviews, missed depots, lack of medical staff leading to long waits for medical reviews, and incident reports of a range of concerning HR issues.

Finding 13 - Serious incident review

The internal report was lengthy, overly detailed and went well beyond the expected policy timescales.

Family engagement by the lead investigator throughout the initial investigation process was initially very positive, but the Trust has not followed through on the promise to keep in touch about progress.

There is evidence that there are actions in progress to address the recommendations.

[10] *Galatean Risk and Safety Technology.* https://www.egrist.org/

Finding 14 - Interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. The local Multi-Agency Public Protection Arrangements Policy is overdue for review.

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

North Cumbria CCG has carried out actions in relation to previous recommendations.

Finding 15 - Domestic abuse

In March 2018 there was no routine enquiry by police about the safety of Mr M's parents, after it was reported that his parents had returned his knives because they had felt it was not safe to refuse.

The GP did not make routine enquiries about domestic abuse.

Cumbria County Council managers did not make routine enquiries about domestic abuse.

Trust staff made no enquiries about safety in relation to the family in March or October 2018.

Finding 16 - Domestic abuse local strategy

There is no implementation plan for the current Safer Cumbria domestic abuse strategy.

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

Finding 17 - Matricide

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

Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

Recommendations

Recommendation 1
NHS North Cumbria CCG should ensure that referrals for a carer's assessment are made by GPs when carer responsibilities are indicated.

Recommendation 2
Cumbria Constabulary must ensure that where an external referral is made for an adult at risk, the content of the referral must include the relevant detail of the information in the Incident Log and Intelligence Reports.

Recommendation 3
Cumbria Constabulary must ensure that safeguarding plans are created for offenders identified as 'adults at risk' and/or vulnerable.

Recommendation 4
Cumbria Constabulary must develop a clearly defined process for how concerns regarding a person's mental health can be escalated within the force and between other agencies.

Recommendation 5
Cumbria Constabulary must ensure that information regarding individuals convicted of a serious offence, but who are detained under Part Three of the Mental Health Act, is appropriately logged, and managed using the relevant system.

Recommendation 6
The Trust must ensure that for patients on CPA, the GP practice is kept informed of care planning, CPA reviews and developments.

Recommendation 7
The Trust must ensure that evidence-based treatment plans that are in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management are in place, for all appropriate service users.

Recommendation 8
The Trust must develop systems that ensure there is consistent monitoring and maintenance of expected standards within the CPA Policy.

Recommendation 9
The Trust must provide assurance that there is a system in place that ensures all patients receive depot medication as prescribed, and that records are made both in the medication chart and the electronic clinical record.

Recommendation 10
The Trust must ensure that there is a comprehensive admission and discharge policy for Yewdale ward which includes care planning, risk management and communication with community mental health teams and family/carers.

Recommendation 11
The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment.

Recommendation 12
The Trust must ensure that referrals for carer's assessments are routinely part of care planning and risk assessment.

Recommendation 13
The Trust must ensure that changes to their risk assessment tools are informed by current research and recommendations from independent bodies. Any newly developed tools should be based on current knowledge and informed by independent experts in risk assessment in mental health services.
They should also be subject to independent evaluation by experts in risk assessment before they are implemented.

Recommendation 14
The Trust must ensure systems are in place to maintain expected standards in clinical risk assessment and planning.

Recommendation 15
The Trust must ensure that there are standards in place for the medical review of patients in Allerdale CMHART, and systems to ensure that standards are maintained.

Recommendation 16
The Trust must ensure that all service users who are prescribed an anti-psychotic have access to an annual psychiatric review, either with a doctor or a non-medical prescriber.

Recommendation 17
The Trust and CCG must provide assurance that the quality and management concerns in Allerdale CMHART have been addressed.

Recommendation 18
The Trust and CCG must ensure that serious incident investigations are carried out at the appropriate levels and within expected timescales.

Recommendation 19

The Trust must provide evidence of assurance of the serious incident investigation action plan implementation, that is then shared with Commissioners

Recommendation 20
The Cumbria MAPPA/MARE partnership agencies: Cumbria Partnership NHS Foundation Trust[11]/Cumbria Constabulary/Cumbria Probation Trust/Cumbria County Council Adult Social Care should carry out an update of the current policy, to include audit of whether the MARE process is being used appropriately and including lessons identified in this review.

Recommendation 21
Safer Cumbria and local Community Safety Partnerships should develop systems to ensure there is oversight of the implementation of action plans from Domestic Homicide Reviews.

Recommendation 22
NHS North Cumbria CCG must develop and implement policies to support routine enquiry by GPs about domestic abuse.

Recommendation 22
NHS North Cumbria CCG must develop and implement policies to support routine enquiry by GPs about domestic abuse.

Recommendation 23
Cumbria County Council must develop and implement employment policies to support routine enquiry about domestic abuse.

Recommendation 24
The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members.

Recommendation 25
The Trust must ensure that where risk to family members is reported, risk assessment must be updated, and victim safety planning becomes part of the risk management plan.

[11] *now CNTW*

Recommendation 26
Safer Cumbria must develop and implement a comprehensive domestic abuse strategy which includes learning from this review.

Recommendation 27
The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy, and procedures.

Recommendation 28
The Home Office should incorporate learning about matricide and parricide into domestic abuse prevention strategies.

2. Establishing the joint review

Decision-making

2.1 This is a joint review which has been commissioned by NHS England NHS Improvement, and West Cumbria CSP. The Domestic Homicide Review (DHR) is carried out in accordance with the statutory requirement set out in Section 9 of the Domestic Violence, Crime and Victims Act 2004.[12] The independent investigation follows the NHS England Serious Incident Framework (March 2015)[13] and Department of Health guidance on Article 2 of the European Convention on Human Rights[14] and the investigation of serious incidents in mental health services.

2.2 A domestic homicide review must, according to the Act, be a review 'of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- A person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself, held with a view to identifying the lessons to be learnt from the death'.

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

2.4 West Cumbria Community Safety Partnership (CSP) was notified on the day of her death in January 2019. As a result of the notification, a meeting was held on 19 February 2019, chaired by the West Cumbria Community Safety Partnership Chair. At this meeting, the police provided a summary of the incident. At this point, it was believed that there was no known history of domestic abuse, but Mr M was known to mental health services. Agencies were asked to ensure that all records were secured in preparation for the production of a chronology and Individual Management review (IMR).

2.5 The following organisations were present at the first meeting:

- West Cumbria Community Safety Partnership.
- Allerdale Borough Council
- Cumbria County Council Adult Social Care.
- Community Rehabilitation Company.

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

[13] *NHS England Serious Incident Framework March 2015.* https://www.england.nhs.uk/wp-content/uploads/2020/08/serious-incidnt-framwrk.pdf

[14] *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

- Probation Service.
- Unity (Greater Manchester Mental Health NHS Foundation Trust/GMMH).
- Cumbria Partnership NHS Foundation Trust (CPFT/now CNTW).[15]
- North Cumbria Clinical Commissioning Group.
- Cumbria Constabulary.
- NHS England.

2.6 A chronology was prepared with the information known by the different agencies and reports and IMRs were commissioned from:

- Cumbria Constabulary.
- Allerdale Borough Council/Adult Social Care.
- NHS North Cumbria Clinical Commissioning Group, covering GPs for both.
- North West Ambulance Service.
- Cumbria Partnership NHS Foundation Trust in the form of a Root Cause Analysis Investigation Report (provided in October 2019).
- Castles & Coasts Housing Association.

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

2.8 The circumstances of the homicide also met the criteria for an independent mental health homicide investigation to be commissioned by NHS England. This meeting of the West Cumbria Community Safety Partnership on 19 February 2019 made the decision that there should be one process only, and a joint review should be commissioned. This investigation will be referred to as the joint review, with NHS England taking the lead for commissioning and oversight.

2.9 Niche Health & Social Care Consulting (Niche) were appointed to carry out the joint review starting in June 2019, and the joint review panel met for the first time in August 2019. There followed further meetings and discussions up to July 2020. All panel members fully engaged in the process, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings, additional work was undertaken via email, telephone and face-to-face meetings.

2.10 The review was completed in July 2020.

2.11 The Guidance[16] for the conduct of DHRs states that a decision to hold a

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[15] *CPFT became Cumbria Northumberland Tyne & Wear NHS Foundation Trust in October 2019.*

[16] *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews* *https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory- Guidance-161206.pdf*

Domestic Homicide Review should be taken within one month of the homicide coming to the attention of the Community Safety Partnership and says that the review should be completed within a further six months.

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

- As a result of delays in the production of the Trust internal report.
- Practical restrictions due to COVID 19.

2.13 The joint review was carried out by Niche, with Dr Carol Rooney, Associate Director, as the independent Chair. Carol has completed many independent mental health homicide independent investigations commissioned by NHS England, including a previous combined DHR. She has completed the 'Advocacy After Fatal Domestic Abuse'[17] DHR Chair accredited training and attended seminars and networking events on the subject of domestic abuse.

2.14 The Niche review panel consisted of:

Name and job title	Role
Elizabeth Donovan Senior investigator	NHS report author
Dr Huw Stone Consultant forensic psychiatrist	Mental health clinical expertise
Nicola Douglas Children and Health Team Leader, Standing Together Against Domestic Violence	Domestic abuse expertise
Sharon Conlon Safeguarding lead	Safeguarding expertise
John Kelly Retired senior police officer	Police expertise

2.15 Internal supervision and quality assurance were provided by Nick Moor, Partner, Niche.

2.16 The Home Office gave approval for publication of the report in March 2022.

Confidentiality

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

2.18 Medical records were shared by NHS organisations under the relevant

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

Caldicott Guardian[18] processes.

2.19 Following legal review, the report has been shared in order to disseminate the learning.

Family involvement

2.20 The family had been involved in meetings and information sharing as part of the Cumbria Partnerships NHS Foundation Trust (CPFT) Trust internal investigation review. We did not make contact with the family until the internal investigation had been completed in October 2019.

2.21 It was agreed by the panel that the Chair and NHS review author would seek to meet with the family and an introduction would be made with the involvement of the charity 'Hundred Families'.[19]

2.22 We wrote to the family shortly after the appointment of Niche introducing ourselves, setting out the purpose of the review and providing the draft terms of reference.

2.23 We met Annie's son Daniel and her husband Len in December 2019. Daniel agreed to be the single point of contact with the family. The family were supported by Julian Hendy from Hundred Families, and by the Victim Support National Homicide Service[20]. We offered information about AAFDA,[21] but the family did not wish to take this up. They advised that they were being well supported by their advocate and the Homicide Victim Support Service.

2.24 The family asked several questions which they wished to be answered, and these were incorporated into the terms of reference (see Appendix D family questions). The family have requested that Annie's own name be used rather than a pseudonym, because they want her to be recognised in this review. They have also requested that the names of her husband Len and son Daniel should be included.

2.25 We kept in touch with Daniel by regular email and provided a draft copy of the report for the family to comment on in December 2020.

2.26 Contact with a close friend of Annie's was made and we also corresponded with her employers.

2.27 We would like to thank the family for their engagement and contribution that they have made to this review. The family have however fed back that they would have liked us to have spent more time with them to understand the

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

[19] *Hundred families are a charity providing practical information for families affected by mental health homicides in Britain. http://www.hundredfamilies.org/*

20 https://www.victimsupport.org.uk/more-us/why-choose-us/specialist-services/homicide-service/

21 AAFDA is a charity providing advocacy after fatal domestic abuse. https://aafda.org.uk/

effect that providing care for Mr M had on the family, particularly on his parents. The family were provided with a copy of the report in December 2020.

2.28 The family accepted many of the learning points in the report, but remain unhappy that the risks that they perceived to be obvious were not identified and acted upon by services. They would like feedback from CNTW about measures taken to ensure accountability and minimise the risk of a similar occurrence.

2.29 We were unable to meet with Mr M in early 2020 due to the national pandemic restrictions on travel and meetings. We had a call with his current Consultant Psychiatrist to help the review to understand his diagnosis and treatment.

2.30 We were able to speak to Mr M by video call in November 2020, and he said he was very mentally unwell at the time of the homicide and had been taking drugs. We met him in person in August 2021, and he again said he had been taking drugs and was very mentally unwell at the time.

Terms of reference

2.31 The terms of reference are provided in full at Appendix A.

2.32 The overall purpose of the joint review is to:

- Identify any gaps, deficiencies or omissions in the care and treatment received by the perpetrator which could have predicted or prevented the incident.
- Identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from October 2017 to the incident occurring in January 2019.

2.33 The joint review will:

- Consider care provided from the date of Mr M 's last detention under the Mental Health Act in 2012, with a focus on the period from October 2017 to the incident occurring in January 2019.
- Request individual management reviews (IMR) by each of the agencies defined in Section 9 of the Act and invite responses from any other relevant agencies, groups or individuals identified through the process of the review.
- Seek the involvement of family, employers, neighbours and friends to provide a robust analysis of the events.
- Produce a report which summarises the chronology of the events, including the actions of involved agencies, analyses and comments on the actions taken and makes any required recommendations regarding safeguarding where domestic abuse is a feature.

- Aim to produce the report within the timescales suggested by the Statutory Guidance subject to:
    - guidance from the police as to any sub-judice issues; and sensitivity in relation to the concerns of the family, particularly in relation to parallel enquiries, the inquest process, and any other emerging issues.

Equality and diversity

2.34 Throughout this review process the Panel has considered the issues of equality, in particular the nine protected characteristics under the Equality Act 2010. These are:

1. Age.
2. Disability.
3. Gender reassignment.
4. Marriage or civil partnership (in employment only).
5. Pregnancy and maternity.
6. Race.
7. Religion or belief.
8. Sex.
9. Sexual orientation.

2.35 Women's Aid state 'domestic abuse perpetrated by men against women is a distinct phenomenon rooted in women's unequal status in society and oppressive social constructions of gender and family'.[22] Women are more likely than men to be killed by partners/ex-partners. In 2019 the number of female homicide victims in England and Wales rose to the highest level since 2006.

2.36 There were 241 female victims of murder, manslaughter, and infanticide in the 12 months to the end of March 2019, up 10% on the previous year. The number of separate homicide incidents rose to 662, up from 644 the previous year, according to the Office for National Statistics (ONS).[23] Almost half (48%) of female victims were killed in a domestic homicide, with the suspect a partner or ex-partner in 38% of cases. The ONS collects data on the relationship of victims to perpetrator of homicides under the headings partner/ex-partner, other family, friends or acquaintances, stranger, other known, and no suspect. There were nine female victims killed by 'another family member' in the year ending March 2019.

2.37 Between April 2014 and March 2017, the Home Office Domestic Homicide Index recorded 400 domestic homicides, of which 59 involved the killing of

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[22] *Women's Aid what is domestic abuse? https://www.womensaid.org.uk/information-support/what-is-domestic- abuse/domestic-abuse-is-a-gendered-crime/*

[23] *Homicide in England and Wales: year ending March 2019. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch 2019*

parents, or parricide (almost 15% of all domestic homicides).[24]

2.38 However, the annual numbers are too small for any statistical analysis to be made. The 2017 Femicide census[25] showed that ten women were killed by children (all sons) in 2016. The Standing Together DHR Case Analysis (2016)[26] showed that when parents are killed it is typically by their sons.

2.39 Recent research into domestic homicide of older people showed that 'older people are almost as likely to be killed by a partner as they are their child'.27 There is also the cumulative nature of discrimination that older women face and the 'triple jeopardy' in that they are women, of older age and have experienced abuse.[28]

2.40 As part of the terms of reference we have reviewed information with regard to Annie's potential vulnerability. She was not an 'adult at risk' in the meaning of the Care Act 2014,[29] (see safeguarding section) and her family did not regard her as vulnerable in any way.

Structure of the report

2.41 Section 3 sets out the details of the chronology of contact with Annie as known to relevant agencies, with analysis against the relevant terms of reference.

2.42 Section 4 sets out the details of the chronology of contact with Mr M as known to relevant agencies, with analysis against the relevant terms of reference.

2.43 Section 5 is a narrative chronology of Mr M 's treatment by mental health services.

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

2.45 Section 7 reviews the Trust internal report and progress on the action plan.

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

2.47 Section 9 sets out our overall conclusions and recommendations.

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

[25] https://www.womensaid.org.uk/wp-content/uploads/2018/12/Femicide-Census-of-2017.pdf

[26] *https://coercivecontrol.ripfa.org.uk/wp-content/uploads/Standing_together_dom_homicide_review_analysis.pdf*

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

[28] *Penhale, B. (2003) Older Women, Domestic Violence, and Elder Abuse: A Review of Commonalities, Differences, and Shared Approaches. Journal of Elder Abuse & Neglect, Volume 15, 2003 - Issue 3-4,*

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

3. Background and agency involvement - Annie

3.1 Information about Annie was gathered from her GP notes, from her family and a friend and colleague. The agencies that submitted IMRs are dealt with in a narrative commentary, which includes analysis relevant to the terms of reference.

3.2 The family have provided us with their perspective, which has given an insight into their experiences. We have been given a sense of Annie's qualities and her importance in the family, as well as the family's experience of caring for Mr M over many years. We were told that caring for Mr M did place a strain on the family and that Annie in particular was emotionally affected. His needs and worrying about what trouble he may be in did take up the family's time and energy, however we did not find any evidence of coercive or controlling behaviour by Mr M. Mr M lived independently and there were no instances of any economic abuse found.

Annie

3.3 Annie and her husband Len had lived in Dearham for many years. They still lived in the family home where they had raised their two sons. She was described as the 'powerhouse' of the family, she was forthright with her views and the family discussed everything.

3.4 Her granddaughters loved spending time with her, and it is a source of terrible sadness that her new grandson will never get to know her.

3.5 Annie trained as a registered nurse and worked as staff nurse at Dovenby Hall mental health hospital and had a nursing career in the NHS.

3.6 When she was semi-retired in 2017 and 2018, she worked part time in a day centre for people with learning disabilities, run by Cumbria County Council. She retired completely in late 2018 aged 69.

3.7 We asked to speak to friends of Annie's and were given contact details for a close friend and a friend that she worked with. The first individual was unable to speak to us because of personal circumstances. We spoke to Annie's friend and colleague, who described her as a 'legend' and a lovely woman who was the life and soul at work. They had listened to her talk about caring for Mr M and knew it was difficult, but that she cared about him regardless. She is greatly missed at her workplace, and by her friends.

GP practice

3.8 Annie was registered with Castlegate GP Surgery, Cockermouth, which is commissioned by NHS North Cumbria Clinical Commissioning Group (CCG). This was the only external service involved directly with Annie, and they provided an IMR which described care provided and any lessons learnt.

3.9 We were also provided with a chronology by NWAS which described the response to the 999 'call made by Mr M in late January 2019.

3.10 From 2004 onwards Annie had requested support from her GP, describing stress and anxiety related to times when Mr M was unwell or at risk. She described feeling worried that he was not getting enough support from mental health services and was especially upset and anxious after he was stabbed in Blackburn in summer 2004. She reported difficulty sleeping and feeling sweaty and anxious, and kept thinking that he could have died. She was prescribed a short course of diazepam[30] to be taken as needed. Annie felt worse over the Christmas 2005 period, when Mr M came to stay. Her mother was also ill with dementia and this was described by her GP as a time of great stress for her.

3.11 At this time, she was signed off work with stress and agreed to be referred for counselling. She was prescribed paroxetine,[31] an antidepressant, and referred to psychological services for counselling. She did not attend the first appointment offered, and the GP requested that a further offer be made. She was later discharged because she had not attended.

3.12 Annie described Mr M as becoming more violent and confused in November 2006. The GP did not ask whether Annie felt safe or whether there was a safety plan for her.

3.13 She had a history of gastrointestinal problems since the early 1990s for which she saw various specialists, and after having a minor operation was treated with medication.

3.14 In March 2008 two main stressors were discussed, Annie's mother died, and Mr M had been arrested. She described having a good network of friends and good support at home, but her mood was still low, and she was not eating or sleeping well. The GP asked her to complete a patient health questionnaire (PHQ-9). [32] The PHQ-9 is a self-administered tool used to monitor the severity of depression and response to treatment. Her score at that time was 22/27, which is in the 'severe' range.

3.15 She was offered a referral for counselling or cognitive behaviour therapy, but she was reluctant to attend. She was still signed off work with depression and was taking medication. A further PHQ-9 was done in May 2008, with a score of 17/27, which is 'moderately severe' but showed an improvement.

3.16 The GP offered medication and support through this difficult period and used the appropriate tool (PHQ-9) to provide an objective test of her response to treatment. She was seen for regular reviews until she returned to work in June 2008, feeling much better.

3.17 There was minimal contact with her GP during the next few years, until in November 2012 Annie was referred to an Ear Nose and Throat specialist at

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[30] *Diazepam belongs to a group of medicines called benzodiazepines. It is used to treat anxiety, muscle spasms and fits (seizures).* https://www.nhs.uk/medicines/diazepam/

[31] *Paroxetine is a type of antidepressant known as an SSRI (selective serotonin reuptake inhibitor.* https://www.nhs.uk/medicines/paroxetine/

[32] *Patient Health Questionnaire (PHQ-9).* https://patient.info/doctor/patient-health-questionnaire-phq-9

West Cumberland Hospital. She had suffered from hearing problems for many years, which had worsened over the previous six months. Hearing loss in both ears was diagnosed and hearing aids were prescribed.

3.18 In July 2014 Annie again sought support for stress and anxiety, at that time Mr M was living with his parents temporarily because they were worried about him. She did not want to take antidepressants but was signed off work and agreed to see First Step[33] for counselling/support. She described herself as constantly worried but being off work was a help. She was reviewed at regular intervals by the GP, and said she was seeing First Step which was helpful. She felt better by December 2014 and told the GP her manager had agreed a phased return. She was signed as fit to return to work in December 2014 and did not see the GP again for two years.

3.19 The GP appears to have provided appropriate and helpful treatment and support, although there were no enquiries about accessing support as a carer or about whether she had any concerns about her safety.

3.20 Annie went to her GP again in October 2016, saying she felt very stressed, she had been caring for a friend who was terminally ill, and Mr M was staying with them at the time. She described feeling 'shaky' and 'not right', and agreed to try propranolol.[34] This helped a little, but did not help with her low mood, and in December 2016 she agreed to try an antidepressant, sertraline.[35] There is no record of Annie being offered a PHQ-9 at this time.

3.21 The IMR notes that there was a missed opportunity to ask her if she felt safe at home at this time, and that it would be reasonable to expect the GP to have asked her.

3.22 There were no 'routine enquiry' questions asked about domestic violence or safety.[36] The guidance in place at the time was 'Responding to domestic abuse: a handbook for health professionals' (2005). The 2005 Guidance states leaders should:

- 'Create strategies and policies for delivering local service provision which reflect national guidance.
- Place at the heart of decision making the safety of women and children who have experienced abuse.
- Participate fully in multiagency initiatives; and monitor, evaluate and audit health services' domestic abuse initiatives and collect appropriate data'.

3.23 The current advice for health professionals was published in 2016,[34] and the NICE quality standard 'Domestic violence and abuse' was published in

[33] *First step is a talking therapy service provided by CPFT at the time.*

[34] *Propranolol belongs to a group of medicines called beta blockers. Its used to treat heart problems, help with anxiety and prevent migraines. https://www.nhs.uk/medicines/propranolol/*

[35] *Sertraline is a type of antidepressant known as a selective serotonin reuptake inhibitor (SSRI). https://www.nhs.uk/medicines/sertraline/*

[36] *Responding to domestic abuse: a handbook for health professionals 2005, p99 http://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf*

2016.[37] The expectation is that people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion.

3.24 Regular reviews of her medication and presentation were carried out, but without the use of an evidence-based tool such as PHQ-9. NICE guidance for the care of people with depression advises that 'when assessing a person with suspected depression, consider using a validated measure (for example, for symptoms, functions and/or disability) to inform and evaluate treatment'.[38]

3.25 It was noted she felt she should leave work and planned to hand in her notice in April 2017. By August 2017 she reported feeling much better, and she was to be reviewed in six months. This review did not take place, and she attended the surgery only for routine screening, and a hearing referral. She last attended the surgery on 17 January 2019, with sinusitis symptoms.

3.26 The NHS North Cumbria CCG IMR noted that there were no policies in place which guided GP practice staff about domestic violence, and local processes such as a Multi-Agency Risk Assessment Conference (MARAC). [39]

3.27 It was also suggested that new approaches such as the use of Health & Wellbeing and Living well coaches, and Primary Care Networks might be helpful in this kind of family situation in the future.

3.28 The CCG informed us that some GP practices have developed their own policies and the CCG is in discussion about the development of a standard process and Policy. The expectation is that a Practice would have access to a Domestic Abuse Policy.

3.29 In the interim there is a CCG Domestic Abuse and the Workplace Policy. Practices have also been signposted to advice on the Royal College of General Practitioner's website, and Safe Lives and MARAC materials have been circulated.

3.30 The CCG has recently agreed (in 2020) in principle with Cumbria constabulary and other agencies that weekly MARAC meetings will be held (they are currently monthly). The CCG will engage with the working group and the intention is to continue to engage General Practice and promote and facilitate the proportionate sharing of MARAC information sharing with GPs, if possible, via a systematised process.

3.31 The judge described Annie as a 'vulnerable woman' in Mr M 's trial. This appears to refer to her vulnerability in being attacked whilst at home watching television, rather than a reference to an ongoing vulnerability. The Care Act

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[37] *NICE: Domestic violence and abuse, Quality standard [QS116], February 2016.* https://www.nice.org.uk/guidance/qs116

[38] *NICE: Depression in adults: recognition and management, Clinical Guideline (CG90), October 2009.* https://www.nice.org.uk/guidance/cg90/chapter/1-Guidance#care-of-all-people-with-depression

[39] *A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed.* https://www.reducingtherisk.org.uk/cms/content/marac

(2014) defines an adult at risk as someone over the age of 18 who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs);
- Is experiencing, or is at risk of, abuse or neglect; and
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

3.32 There is no evidence to suggest that Annie should have been considered as an 'adult at risk' in accordance with the Care Act 2014 (see safeguarding section). However the family have told us that living with Mr M as part of the family meant that they all felt as though he was capable of harm to any of them. His brother told us that he had always thought he would harm their parents and was not surprised when he got the call from the Police.

North West Ambulance Service (NWAS)

3.33 The initial emergency call to NWAS was made by Mr M, stating that he had killed his mother. He was described as breathless and agitated. The call was categorised as the highest priority with an expected response time of between eight and 15 minutes. This is in line with government ambulance response standards of the Ambulance Response Programme. The call responder would normally expect to follow the standard cardiac response pathway, asking questions about breathing and presentation. The caller kept hanging up or not responding and became impatient with the questions. A call back was initiated each time, as expected by protocols. The call handler also called the Police, as would be expected where a potential weapon may be present, and a warning was issued to the attending crew.

3.34 Crew safety is a priority during incidents where a there is a threat of violence or a patient is reported to have received injuries due to violence. The warning is sent via the Medical Display Terminal which is situated in the vehicle and all allocated incident information for that vehicle is passed. The Medical Display Terminal is also connected to the satnav terminal, so addresses are automatically programmed for crews to follow directions.

3.35 The rapid response vehicle is single crewed and Emergency Medical Dispatchers[40] will make verbal radio contact alongside the MDT information.

3.36 It is expected practice for ambulance crews to make their way to the scene but to stand off until confirmation of Police attendance is received. Where practical crews would situate themselves out of sight of addresses.

3.37 The address was situated in a built-up residential area on a long, winding road. The rapid response vehicle approached the address but was around a bend. The male was outside the property and was walking about the road. He saw the rapid response vehicle and began walking towards it.

[40] *Emergency medical dispatchers are the call handlers who respond to ambulance 999 calls.*

3.38 The Paramedic felt she could not drive past or turn the vehicle around so made the decision to approach with caution. The male was on the pavement to the opposite side of the vehicle. She stopped the vehicle, got out keeping the vehicle between them and asked the male if he had made the phone call. He confirmed he had, and he gave his name. He was described as very calm throughout.

3.39 The Paramedic explained to Mr M that she needed to go into the house, but she needed him to stay outside which he stated he would. He was unarmed. She explained that the Police were on the way and another ambulance was also attending.

3.40 This is not ideal practice, but the Paramedic took every precaution to ensure her safety. She felt by driving by once she had been seen could have caused unnecessary distress and possible further agitation. She got out of the car but kept the vehicle between them to protect herself. She felt that if she had stayed in the vehicle and put the window down for Mr M to approach the vehicle this could have been more dangerous if he was still feeling violent. By getting out of the vehicle she could at least run away and press her emergency alert button on her radio if she needed to. When this button is used it sends a high-pitched alarm to every user and Control centre have immediate communication to the individual user and can hear everything.

3.41 It is a difficult analysis to make when faced with this situation. Ambulance crews need to be close enough to the scene to treat patients a soon as it is safe to do so without causing unnecessary delay, but far enough to allow Police to secure the scene.

3.42 The police were on scene extremely quickly. They secured Mr M, before the Paramedic went into the house. The Paramedic was accompanied by a Police Officer into the property.

3.43 The Police Officer assisted the Paramedic until the crew arrived which is good practice. Police Officers have basic first aid training and the Paramedic utilised this skill to begin the resuscitation attempt.

3.44 It is expected practice where possible to request assistance from specialist services. This was quickly identified as a traumatic cardiac arrest. The Helicopter Emergency Medical Service (HEMS) is a specialist service that provides air support and is operated by doctors who specialise in pre-hospital trauma care and can perform various advanced out of hospital procedures that a Paramedic cannot. A doctor from the HEMS team made their way to the address to assist the land crews.

3.45 Annie died as a result of her injuries and this was diagnosed at the scene. The patient report form is completed along with a diagnosis of death form. A copy of these documents is given to the Police for their records.

Cumbria County Council

3.46 Annie was employed in a part-time capacity (12 hours a week) by Cumbria

County Council. An IMR was not requested formally, but information regarding her work and health was subsequently shared with this review. The manager concerned was not available to discuss issues directly, and our contact was with the Human Resources department at Cumbria County Council.

3.47 We have been provided with Occupational Health (OH) reports for Annie from November 2016, January 2017, and March 2017.

3.48 Annie was referred to OH by her manager in November 2016, after a period of sickness absence with stress and depression. At this time Annie said that her illness was due to family issues. She was not willing to discuss any details, and she refused any Occupational Health Support. This was referred back to her manager to consider whether to take the referral any further.

3.49 A further referral to OH was made in January 2017. At this time Annie had been absent from work for over three months. The OH advice was that she was suffering with anxiety and depression. She was on appropriate treatment and was receiving counselling therapy. She stated that the reason for her depression was purely personal and there were no work-related issues. It was noted she said her care responsibilities for her son (Mr M) had increased and this had made her difficulties worse. The advice was to meet with her GP to discuss her medication and support. She was judged to be unfit for work at that time but expected to return to work when she recovered.

3.50 Annie was seen again in March 2017 for a follow up OH appointment. She remained too unwell for work, as she had been since October 2016. Anxiety and depression symptoms were still present, and she was to see her GP for a review at the end of March 2017. Advice was given about a possible phased return to work when she became well enough, and it was noted that she had discussed possible retirement with her manager.

3.51 A further review appointment was suggested within a month. It was advised that if she did return to work, there should be regular (weekly) meetings with her line manager ‘to enable her to voice any concerns as they arise, these can then be reduced as both parties see fit’.

3.52 We have not been provided with any further information about this process, or whether Annie returned to work. Annie did however retire in May 2018.

3.53 Cumbria County Council provides a section on their website for employee support regarding a number of health and wellbeing issues.[41] There is a section regarding supporting employees with possible domestic abuse. This section contains information about local and national resources and links to websites which can provide support, advocacy, and practical help. The Council also has an employee programme that provides managers and staff with a structure to work through if there is illness or disability that affects their work.

3.54 Annie was a former nurse and experienced support worker with people with

[41] *Cumbria County Council employee information.* https://www.cumbria.gov.uk/employeeinformation/wellbeing.asp#

mental health issues and learning disabilities. It was clear that she felt that her son was not getting the help she felt he needed. She took her caring role seriously, deciding to take early retirement to spend more time supporting him. There were no offers of support in her role as a carer.

Finding 1 - GP/North Cumbria CCG/NWAS

While the GP surgery provided support and treatment in times of stress, there were missed opportunities to explore whether she required support as a carer or had any concerns about her own safety. No routine enquiries about domestic abuse were made, and no referral for a carer's assessment was made.

The GP practice did not have policies in place to support enquiries about domestic abuse or offer any risk assessment tools.

The approach of NWAS emergency teams was within expected practice.

Recommendation 1
NHS North Cumbria CCG must ensure that referrals for a carer's assessment are made by GPs when carer responsibilities are indicated.

4. Background and agency involvement - Mr M

4.1 The agencies that submitted IMRs are dealt with in a narrative commentary for Mr M, which includes analysis relevant to the terms of reference. The main analysis of Mr M 's mental health care and treatment is at Section 6.

4.2 IMRs were provided by NHS North Cumbria CCG, Cumbria County Council Adult Social Care, and Cumbria Constabulary. A summary of involvement was provided by the landlord of his flat in Workington. This section reviews the information in the individual IMRs.

Mr M

4.3 The family had always lived in Cumbria, and Mr M is the eldest of the two sons. It is recorded that he reached his normal developmental milestones, although his mother had described him as being overactive as a toddler. He had an operation at nine weeks of age for pyloric stenosis (constriction in the stomach). At the age of four he suffered a fractured skull, with a loss of consciousness, following a fall from the curtain from which he had been swinging. He also suffered a fractured left foot at the age of four-and-a-half years.

4.4 Mr M was described as bright at school, obtaining eight GCSEs. He attended a college course and initially worked as a plasterer but was made redundant. He has not worked since the onset of his mental health issues in 1994.

4.5 In 1993 a close friend of Mr M 's died from asthma, and his grandfather also died in the same year. It was reported that Mr M found these experiences very distressing and developed breathing difficulties, especially at night.

4.6 When he was 20 years old in 1994, his parents were concerned about him, and after a GP consultation he was referred to a psychiatrist. Annie was concerned that he appeared to be preoccupied and distracted and talked and giggled to himself.

4.7 The CNTW internal serious incident investigation was provided to us in October 2019. Mr M 's mental health care is summarised in a narrative chronology in Section 5. His care and treatment are examined in detail under the individual terms of reference in Section 6.

4.8 Mr M had his own flat in Workington, where he had lived since 2006. This was a tenancy agreed with Castle & Coasts Housing Association, who took over as provider in 2017. This was a landlord and tenant relationship only and did not provide any additional support.

4.9 There was a support package initially provided by Richmond Fellowship,[42] but this ended more than seven years prior to the homicide, which is beyond their time frame for record keeping. They were therefore unable to provide the review with a chronology or IMR.

Cumbria Constabulary

4.10 Mr M has been involved with the police dating back to 1995.

4.11 A summary of their involvement is provided below:

Date	Issue	Outcome
1995	Armed Robbery	Section 37/41 MHA, February 1996 - February 2003.
1996/1997	Missing person alerts	Reported missing from hospitals in Carlisle, returned by police.
2007	Request for MHA assessment support	Attended but no further action required by mental health services.
2007	Arrest for attempted murder, charged with attempted GBH	Section 37/41 MHA February 2008, June 2012.
2012	Police informed of absolute discharge	'Mentally disordered person' file created by the public protection unit.
2014	Attend after concerns raised by a neighbour	Attended, safeguarding concern raised, made contact with mental health services.
2014	Victim of a burglary (alongside other burglaries in the area)	Offender arrested and convicted.
24/3/2018	Neighbour called into Workington police station with concerns	Attended, safeguarding concern raised, made contact with mental health services.

[42] *Richmond Fellowship is part of Recovery Focus, a group of charities with the shared aim to Inspire Recovery Together.* https://www.richmondfellowship.org.uk/

	about Mr M 's mental health	
26/3/2018	Assist with execution of Section 135 MHA	Attended with four officers because of risks, conveyed to Yewdale ward by ambulance.
19/9/2018	Mr M phoned twice to say his neighbour was harassing him	Advised not to take matters into his own hands.
20/9/2018	Neighbour phoned to say Mr M had threatened him with a large knife and assaulted him.	Arrested Mr M for ABH, was under the influence of drink and drugs. Neighbour and another neighbour refused to supply statements, and there was no further action. A vulnerable adults safeguarding report was completed and shared with the local authority.
25/9/2018	Mr M phoned twice to say he had concerns about his neighbour and would attack him again if provoked.	Police attended and he was intoxicated, and also appeared mentally unwell. A vulnerable adults safeguarding report was completed and shared with the local authority. This was also referred to the Trust Liaison & Diversion Team.
26/11/2018	Mr M phoned to report damage to his flat window	Attended, the outer pane of his living room window had been smashed. No CCTV or witnesses, and no forensic evidence at the scene. Crime number allocated but later closed as no evidence.

4.12 The police IMR noted there was a lack of detail in the content of the safeguarding adult referrals made for Mr M in 2018. The referrals made in March and September 2018 did not reflect the detail of the police incident form, particularly in relation to risk concerns and evidence of deterioration in mental health which were observed by police.

4.13 Communication with mental health services did take place at the appropriate times. However, the information conveyed to mental health services (via a safeguarding referral) after the police contact on 24 March 2018 was received by the Trust single point of contact as 'welfare concerns'. The actual incident log reads:

'Mr M 's neighbour attended the front counter of Workington Police station. She had come home late, and Mr M had been waiting for her return. She had said '*not now*' Mr M and went inside from about 0100hrs to 0400hrs that morning Mr M had knocked on her door. She had got up in the morning and seen he had posted several pieces of paper through her letterbox with handwritten notes on which didn't make much sense. They had comments on like '*1.8 million*' '*My solicitor says its illegal' '[name] I'm not bad you know' 'Google my late grandma'* and several more. The neighbour did not feel threatened but was concerned for Mr M 's mental welfare. She said that he was using alcohol/drugs a lot lately. She said he also kept sticking notes in his window and had said to her that he thinks someone is recording him. When she had seen him the previous day, he also made a comment to her that he *'feels like slitting his wrists'*.

4.14 This was summarised to: 'feeling paranoid, feeling like harming himself, but not seen as a risk to himself or others'. The contact with mental health services was reported as 'they were happy that he could be left at his home address and Mr M was given their contact details should he feel the need to speak to anyone and they would arrange a visit to him'. While it could be said that the police discharged their duty by passing information on, the detail was not provided. More detailed information was in fact provided to CMHART several days later by his parents.

4.15 On 27 March 2018, police were requested to assist in the execution of a Section 135 MHA[43] warrant along with mental health services staff. Information conveyed by mental health services indicated that Mr M had recently been seen with knives in his flat. He had been carrying two or three knives for protection, which his mother had removed. He had however been banging on his parents' door the previous morning and they had returned the knives because they had 'not felt safe to refuse him'.

4.16 The police risk assessment at this time was that Mr M was unlikely to comply with the warrant, and four officers, one armed with a taser, were allocated to attend. Mr M in fact did cooperate and came with officers willingly. The police noted that knives were visible in the property but did not seize any items. The notes record that his parents specifically referenced being afraid to take the knives (although the family have told us this was not in fact the case) which should have prompted enquiry about risk to them. There does not appear to have been any routine enquiry about the safety of Mr M 's parents.

4.17 The 19 September 2018 incident with the neighbour were reported to mental health services as a neighbour dispute, and 'words of advice' given. The actual report describes two calls from Mr M to the police. The first call was Mr M stating that he was unhappy that his neighbour was reporting him to the housing association for allowing his dog to mess up the garden, and using

[43] *Section 135 MHA 1983 is a warrant to search for and remove patients. Warrant authorising any constable to enter, if need be by force, any premises specified in the warrant in which that person is believed to be, and, if thought fit, to remove him to a place of safety with a view to the making of an application in respect of him under Part II of this Act, or of other arrangements for his treatment or care.* http://www.legislation.gov.uk/ukpga/1983/20/section/135

drugs, although he did not require police attendance and seemed calm.

4.18 Mr M phoned again at 7.00 pm in an irate state, saying if the police do not sort out his neighbour, he would take matters into his own hands. He said that it would not take much to break a nose or a jaw and he was not bothered about going to prison as that was 'easy'. Police recorded that he sounded as though he had been drinking. After 11.00 pm that day, the neighbour phoned the police to say that Mr M had threatened him with a large kitchen knife and then assaulted him, and he had wrestled Mr M to the floor. Mr M also called the police shortly afterwards to say he had given his neighbour a 'hiding' because he came into his flat, and he wanted to give himself up.

4.19 Mr M was arrested for Actual Bodily Harm in the early hours of 20 September 2018. When spoken to by officers at the scene the neighbour then claimed he had been assaulted outside Mr M 's home address. He claimed he went round at 11.00 pm to check he was ok due to his mental health. He stated that Mr M had not run at him with a knife, he just had lots of knives in his kitchen. The neighbour claimed he left the address and Mr M punched him once in the back of the head causing a small cut on his ear. He claimed the punch caused him to fall to the ground. Mr M was alleged to have then assaulted him further by kicking him in the right shoulder. After arrest Mr M stated that "he walked into the house and I knocked [swears] out of him, and it wasn't ABH. I was gonna kill him and you can tell that to any judge".

4.20 He was not interviewed immediately due to appearing under the influence of substances, and the custody care plan identified him as 'medium risk' and to be observed every hour, and to be interviewed with an appropriate adult in the morning. The neighbour and second neighbour described as a witness, refused to provide witness statements, therefore the case was recorded by the Custody Sergeant as 'NFA' (no further action).

4.21 It is normal practice for the Custody Sergeant to make charging decisions based on the evidence at the time where appropriate. The police referred to the use of their 'threat, harm, risk, investigation opportunities, vulnerability and engagement' model (THRIVE)[44] of risk assessment, which is used to assess the appropriate initial police response to a call for service. This model allows a judgment to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of that decision.

4.22 No safeguarding referral was made. Police assessment and safeguarding procedures historically focus on the victim being vulnerable,[45] not the offender. This was a missed opportunity to share the detail of Mr M 's situation with other agencies. He was however spoken to in custody by Trust Liaison & Diversion staff, although he declined to meet with them formally. The Liaison & Diversion team left a message for CMHART to call and informed them that Mr M had been arrested but released without charge and

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[44] *THRIVE (Threat, Harm, Risk, Investigation Opportunities, Vulnerability and Engagement).* https://www.justiceinspectorates.gov.uk/hmicfrs/glossary/thrive/

[45] *Recognising and responding to vulnerability related risks. Scope of practice guidelines Version 2.1 college of policing.* http://library.college.police.uk/docs/appref/130319-Risk-scoping-final.pdf

had refused any offers of help.

4.23 Mr M called the police three times on 25 September 2018, twice on 101 and once on 999. He told police he had stopped taking his medication and would attack his neighbour again if provoked. He was advised the police would make an appointment to see him if he was worried, and he was advised not to attack his neighbour. A THRIVE assessment was completed but there was no entry made for 'vulnerability'.

4.24 Police attended on the morning of 25 September 2018. Mr M was noted to be agitated and rambling, appearing under the influence of alcohol, and said he had been up all night waiting for the police. He told officers he had schizophrenia and had stopped taking his medication recently as he believed it was not working. Mr M made incoherent allegations about believing his neighbour planned to do him some harm.

4.25 It is recorded that he was clearly paranoid and hyperactive, stating his head was going to 'explode with stress'. Mr M was noted to be happy for an 'adult at risk' (safeguarding) report to be completed, as he wanted help. The Liaison & Diversion Team made contact with CMHART after receiving the safeguarding referral.

4.26 There was no activation of the Multi-Agency Risk Evaluation (MARE)[46]process which was in use at the time. This process was designed to provide a framework for multiagency risk assessment and management for mental health service users who came into contact with criminal justice systems. This only applies to those service users who do not meet the criteria for Multi- Agency Public Protection Arrangements (MAPPA),[47] but are assessed as posing a high risk of serious harm to the public (this is discussed in risk assessment, Section 6).

4.27 In the early hours of Tuesday 15 January 2019, two police officers saw Mr M walking along a country lane with his dog. They stopped and spoke to him and he told them he was struggling with his mental health and had set off on the seven-mile walk to see his parents. The officers gave him a lift to his parents' home, but did not contact mental health services, or his parents, because they recorded no safeguarding concerns.

[46] *Multi Agency Risk Evaluation, Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy. https://proceduresonline.com/trixcms1/media/1120/multi-agency-public-protection-arrangements-multi-agency-risk-evaluation-mappa-mare-pathway-policy.pdf January 2017.*

[47] *Multi-Agency Public Protection Arrangements assess and manage the risks posed by sexual and violent offenders: guidance for the police, prison service and probation trusts. https://www.gov.uk/government/publications/multi-agency-public-protection- arrangements-mappa--2*

Finding 2 - Cumbria Constabulary

Information about risk which had been logged by police was not conveyed to mental health services in sufficient detail.

There was no routine enquiry about the safety of Mr M 's parents after incidents in March 2018, when his mother had removed knives. The notes record that he had been given them back because his parents did not feel able to refuse, however the family state that this was not how they viewed it.

Risks concerns in the incidents of 19/20 September 2018 were not conveyed in appropriate detail.

Police did not activate the Multi-Agency Risk Evaluation (MARE) process in September 2018.

There was a lack of detail and continuity in the police approach to communicating with other agencies about Mr M, given their awareness of his mental health issues.

Recommendation 2
Cumbria Constabulary must ensure that where an external referral is made for an adult at risk, the content of the referral must include the relevant detail of the information in the Incident Log and Intelligence Reports.

Recommendation 3

Cumbria Constabulary must ensure that safeguarding plans are created for offenders identified as 'adults in need' and/or vulnerable.

Recommendation 4

Cumbria Constabulary must develop a clearly defined process for how concerns regarding a person's mental health can be escalated within the force and between other agencies.

Recommendation 5
Cumbria Constabulary must ensure that information regarding individuals convicted of a serious offence, but who are detained under Part Three of the Mental Health Act, is appropriately logged, and managed using the relevant system.

Substance misuse services

4.28 At a medical review in May 2016 Mr M was encouraged to access substance misuse services. He described craving amphetamines although he was not using at the time. The alcohol and drug recovery service for Cumbria is called Unity, which is provided by Greater Manchester Mental Health NHS Foundation Trust (GMMH).[48]

[48] *Unity Substance Misuse Services in Cumbria.* https://www.gmmh.nhs.uk/unity/

4.29 Unity records show that Mr M did self-refer at the end of May 2016, but the referral did not reach the assessment stage. The care coordinator wanted to accompany him to a support group. There is some miscommunication with CMHART about transport and timings, Mr M did attend to join a group session on 24 June 2016 but was turned away because he was 10 minutes late. Unity meeting discussions note that Mr M was to be offered 1:1 sessions given the degree of his issues. Unity contacted CMHART to set up a further appointment but were told that the care coordinator was absent from work. Communication seems to have stalled there, and no further contact was attempted.

4.30 Mr M was noted to say to the care coordinator in August 2016 that he did not wish to attend Unity, and that he was using cannabis but not amphetamines at that time.

4.31 He requested a referral to Unity in November 2017, saying that he was abusing alcohol. This does not appear to have been actioned, although Mr M could have self-referred.

Cumbria County Council/housing

4.32 Mr M has been entitled to aftercare under Section 117 MHA,[49] since his discharge from Section 37/41 MHA in 2012. Under Section 117 MHA the Local Authority and local CCG have a duty to provide aftercare services to patients discharged from Section 37/41 MHA. There was no evidence supplied which clarified whether this was ongoing, or whether he had been discharged from Section 117.

4.33 He had a package of support arranged through Richmond Fellowship as part of his aftercare. There were no notes available for this period, as the local policy is to destroy notes after seven years.

4.34 His initial tenancy for the flat in Workington was with Derwent and Solway Two Castles Housing Association, commencing in 2007. This became Castles & Coasts Housing Association (CCHA) in 2017. The flat was referred to as a 'general needs' property, and there was a landlord and tenant relationship only.

4.35 CCHA were made aware that Mr M had mental health care provided by the Trust but had no direct involvement. There were no concerns that required formal action or safeguarding. When 'low level tenancy issues' arose such as rubbish being left in the garden, the housing team made contact directly with CMHART to resolve these.

4.36 There was one occasion in March 2017 when the housing team were informed by a neighbour that Mr M had moved out of the property, and CMHART was contacted. Mr M contacted the housing team and said he was staying with his mother temporarily, while benefits were being sorted out.

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[49] *Section 117 MHA After-care.* http://www.legislation.gov.uk/ukpga/1983/20/section/117

4.37 Mr M lived independently in his flat from 2007 onwards and maintained this tenancy until January 2019. There were periods where he moved in with his parents while his flat was being decorated, and at other times when his parents felt he needed more support.

4.38 Mr M did not work in paid employment but received financial support via the benefit system. He had no identified social care needs.

4.39 Contact with Cumbria County Council from 2012 onwards was limited to vulnerable adult referrals and mental health act assessment requests, which were all acted upon.

Finding 3 – Cumbria County Council and Unity

Cumbria County Council and Unity inputs were within expected policy and procedure.

GP practice

4.40 Mr M was registered with a different GP practice to Annie. He was registered with Solway Health Services GP practice, Workington which is commissioned by NHS North Cumbria Clinical Commissioning Group (CCG). The CCG provided an IMR which described care provided and any lessons learnt.

4.41 Mr M was reported to have had an accident at home aged five that resulted in a significant head injury, with a fractured skull. He was in hospital for seven weeks.

4.42 From the age of seven to nine he was reported to be regularly using chemicals, lighter fuel, solvents and petrol.

4.43 In his late teens he started to abuse cannabis and amphetamine, with regular use over many years. In 2004 he was stabbed in a fight.

4.44 There was an 'accidental overdose' of heroin in July 2007, and he was admitted to the Carleton Clinic.[50]

4.45 Mr M registered with Solway Health Services in 2009. At this time, he was prescribed clozapine 400mg daily,[51] which was prescribed by the mental health team and issued by a local pharmacy.

4.46 The GP notes record that the mental health team had advised them that his alcohol abuse had increased during 2010. In August 2014 there was an 'accidental amphetamine overdose', and he was admitted to hospital.

4.47 He was on the practice 'mental health register' but there was no recent

[50] *The Carleton Clinic is a hospital in Carlisle. It is made up of six inpatient wards and community clinics.* https://www.cntw.nhs.uk/locations/carleton-clinic/

[51] *Clozapine is an atypical antipsychotic drug that first became available in the UK in 1989 and is used in the treatment of people with schizophrenia who are unresponsive to, or intolerant of, conventional antipsychotic drugs.* https://bnf.nice.org.uk/drug/clozapine.html

documented care plan in his GP record. This would prompt an annual mental health review meeting. A review meeting was held in December 2017, and there was a review planned for February 2019. At the review meeting in 2017 Mr M told the GP that he was not taking drugs but was using 10 units of alcohol a night. He said his mother had now retired and he was living with her while his flat was redecorated. The GP noted that they gave advice about alcohol abuse.

4.48 His last medication review had been in April 2018. There is very little in the GP notes after March/April 2018. There were also no further letters from the Mental Health team in his GP record during that time. For service users cared for under CPA, it would be normal practice to invite representation from primary care, and to send updates to the GP when there are reviews or changes to care and treatment plans. There was no requirement to do this in the CPA policy in place at the time.

4.49 The GP practice rarely saw him except for collection of prescriptions. The 'mental health review' appointments mainly focussed on his physical health and no other concerns were raised. The GP practice staff do not recall any incidents occurring when Mr M attended the practice.

Finding 4 - North Cumbria CCG/GP

The GP dealt with physical health issues, e.g. smoking cessation advice. Mental health concerns were dealt with completely by secondary care.

There was no communication between Mr M 's GP practice and his mother's GP practice, which is within normal expectations.

Mr M 's GP had very little communication from mental health services in 2018.

Recommendation 6
The Trust must ensure that for patients on CPA, the GP practice is kept informed of care planning, CPA reviews and developments.

5. Mental health care and treatment

5.1 Mr M has a history of contact with mental health services dating back to 1994. We have summarised the dates, diagnoses and presenting issues up to 2017.

5.2 We have analysed his care and treatment in detail against the terms of reference from October 2017 onwards in Section 6.

1994 to 1995

5.3 Mr M was first referred, aged 20, to mental health services in May 1994. Following an assessment under the Mental Health Act (MHA), Mr M agreed to an admission and was admitted to the Yewdale ward in June 1994. He was given a diagnosis of 'schizophreniform psychosis' with a history of drug abuse and/or a head injury as precipitating or causative factors. He was prescribed oral chlorpromazine. This was changed to fluphenazine decanoate[52] in August 1994 because he had not been compliant with the oral medication but in November 1994, he was not accepting the depot and returned to the oral medication.

5.4 In March 1995 Mr M was reported to be mentally well, compliant with treatment and denied any drug use.

5.5 In June 1995 he was arrested on a charge of armed robbery and was remanded to prison, where he presented as psychotic. On 11 July 1995 he was transferred from prison to the medium secure unit at St Nicholas Hospital, Newcastle under Section 48/49 MHA.[53]

1996 to 2003: First Section 37/41 MHA

5.6 Mr M appeared at Carlisle Crown Court in February 1996. The forensic consultant psychiatrist stated that he had a mental illness, most probably schizophrenia, and that at the time of the robbery he had been suffering from this illness. Mr M was detained under Section 37/41 MHA (Hospital Order and Restriction Order), which was overseen by the Home Office, now the Ministry of Justice (MoJ).

5.7 Mr M 's illness responded to treatment and he was transferred to Rowanwood Psychiatric Intensive Care Unit (PICU) at Garlands Hospital, Carlisle in May 1996, initially on six months trial leave. His medication when transferred was flupentixol decanoate[54] 80mg every two weeks and chlorpromazine 50mg at night. His depot was decreased and then stopped. In October 1996, it was decided he needed a three-month drug-free trial to

[52] *Fluphenazine decanoate is an injectable long lasting (depot) medication for maintenance in schizophrenia and other psychoses.* https://bnf.nice.org.uk/drug/fluphenazine-decanoate.html

[53] *Section 48/49 Removal to hospital of other prisoners.* https://www.legislation.gov.uk/ukpga/1983/20/section/48

[54] *Flupentixol decanoate is an injectable long lasting (depot) medication for maintenance in schizophrenia and other psychoses.* https://bnf.nice.org.uk/drug/flupentixol-decanoate.html

clarify the nature of his psychosis. By November he was describing symptoms of psychosis again and his mental state deteriorated in December 1996. He was described as volatile overactive, and hearing voices. A urine drug screen was negative. By the end of December 1996, fluphenazine decanoate had been restarted. His diagnosis was schizophrenia.

5.8 During 1997 it appeared his mental state had stabilised and he began home leave, but early on, he absconded from one of these leaves, obtained illicit drugs and turned up near his parent's home. However, by the end of the year he was using home leave without serious incident.

5.9 During 1998 plans were being made to transfer Mr M to an open ward. In May he assaulted another patient by throwing a hot drink on him, which scarred his chest. In August 1998, Mr M transferred to an open ward at West Cumberland Hospital on six months trial leave.

5.10 In March 1999, his Consultant Psychiatrist requested the transfer of Mr M to Rowanwood PICU for a two-week period of 'containment' following incidents of him 'pushing the boundaries'. On admission to Rowanwood PICU, a Urine Drug Screen tested positive for amphetamine and benzodiazepines. In May 1999, he was reviewed by a Forensic Psychiatrist from the Medium Secure Unit who noted residual psychotic symptoms, but recommended planning discharge.

5.11 In March 2000 Mr M was transferred to Kemple View locked rehabilitation unit. His diagnosis on admission was documented as schizophreniform illness precipitated by drug abuse. He remained settled and his mental state was stable throughout the rest of 2000. His anti-psychotic medication was a combination of oral olanzapine[55] and four weekly depot medication.

5.12 A Mental Health Review Tribunal in February 2001 granted a deferred conditional discharge. After six months of increasing leave to 24hr supported accommodation at Almond Villas in Blackburn, the Tribunal agreed to his conditional discharge there in September and he was finally discharged the following month. By the time of his conditional discharge, Mr M was being treated with three different anti-psychotic drugs and medication for side effects (zuclopenthixol decanoate[56] 200mg weekly, olanzapine 10mg at night, trifluoperazine[57] 5mg, three times per day and procyclidine[58] 5mg twice per day).

5.13 During 2002, Mr M remained well, but in October 2002 he returned from home leave smelling of alcohol and describing his mind racing, that he was telepathic and said that he had heard his dead friend speaking to him. These symptoms settled quickly on return to the accommodation.

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

[56] *Zuclopenthixol decanoate is an injection used for maintenance in schizophrenia and paranoid psychoses.* https://bnf.nice.org.uk/drug/zuclopenthixol-decanoate.html

[57] *Trifluoperazine is antipsychotic medication.* https://bnf.nice.org.uk/drug/trifluoperazine.html

[58] *Procyclidine is used to treat side effects of some antipsychotic medication.* https://bnf.nice.org.uk/drug/procyclidine- hydrochloride.html

5.14 In February 2003, the Tribunal agreed to his absolute discharge. Mr M was discharged from Almond Villas in April 2003 to his own accommodation. His medication had been changed to flupentixol decanoate 80mg fortnightly.

2004 to 2008

5.15 Mr M found the transition to living in the community stressful and on 14 April 2004 was admitted informally to Hyndburn ward. He had been abusing alcohol and was using cannabis every day and amphetamines at weekends. He took his own discharge on 26 April 2004. In August 2004 Mr M was the victim of a knife attack, resulting in 18 stitches.

5.16 He tried to move out of Blackburn during January and February 2005, but he was not successful, and he returned to live with his parents in Cumbria in May 2005.

5.17 Mr M moved into a flat in Workington in early 2006. During 2006, Mr M did not fully engage with the community mental health team (CMHT). The CMHT made a referral to the Assertive Outreach Team (AOT) in November 2006, Mr M was not willing to accept a hospital admission but would accept support from AOT.

5.18 During early 2007, Mr M 's engagement with the CMHT was limited, he continued to use amphetamines and his mental health deteriorated. In April 2007 he was under the Crisis Resolution and Home Treatment Team (CRHTT) in addition to AOT. He was admitted informally to the Hadrian Unit[59] in April 2007. He was transferred to the Yewdale ward and discharged on 14 May 2007 to the care of AOT, but still did not engage and he was using cannabis and occasionally amphetamines.

5.19 On 17 September 2007 Mr M was detained under Section 35 MHA[60] following his arrest for the attempted wounding of his brother's friend the previous day. Urine drug screen was positive for cannabis and benzodiazepines. He was started on clozapine. Mr M continued to access illicit drugs while on the ward. Later urine drug testing was positive for amphetamines and benzodiazepines.

2008 to 2012: Second Section 37/41 MHA

5.20 Mr M appeared in the Crown Court on 15 February 2008, he was convicted of one count of intent to do grievous bodily harm. The Court imposed a Section 37/41 MHA, for an indefinite period. In the following months Mr M was compliant with his prescribed medication, used escorted leave with no issues, random drug tests were negative, and he was reported to be stable with no signs of psychosis. During the rest of 2008 Mr M had gradually

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[59] *Hadrian Unit is a mental health inpatient service in Carlisle.*

[60] *Section 35 MHA, Remand to hospital for report on the accused's mental condition.* http://www.legislation.gov.uk/ukpga/1983/20/section/35

increased leave from the ward.

5.21 Reports prepared for the Court at the beginning of 2008, concluded that the best way to reduce Mr M 's risk to the public was to control his psychosis. They went on to say that clozapine appeared to be controlling his symptoms of irritability, hostility, and anger.

5.22 On 27 February 2009, the Tribunal conditionally discharged Mr M. His medication on discharge was clozapine 100mg morning and 300mg night. During the remainder of 2009, Mr M complied with the requirements of the Section 41 conditions.

5.23 Through 2010, Mr M complied with the Section 41 conditions. There was a steady reduction in the dose of clozapine, because of reported side effects.

5.24 By January 2011, his total daily dose of clozapine was 175mg. Mr M continued to engage with mental health services in 2011. In August, the consultant psychiatrist asked the MoJ to consider an absolute discharge, to which they did not agree. In August 2011 service changes led to the AOT being disbanded and the creation of a Community Mental Health and Recovery Team (CMHART).

5.25 Mr M was absolutely discharged by the Tribunal in June 2012. This meant that his care was no longer formally monitored by the Ministry of Justice. He initially engaged with CMHART but in October 2012 he missed six home visits from the team. At his request, clozapine was changed to olanzapine. Mr M was monitored closely by his care coordinator. Olanzapine was increased from 15mg to 20mg in January 2013.

2013 to 2017

5.26 During 2013 Mr M admitted to using amphetamines, and in October 2013 he stopped olanzapine. His mental illness quickly relapsed.

5.27 Mr M stopped taking his medication in October 2013, and he requested a visit from his community psychiatric nurse (CPN). He accepted that he needed medication and had started to take it again.

5.28 His engagement with mental health services reduced, and by April 2014 it was the view of the care coordinator that Mr M was actively disengaging from services. In May 2014 Mr M was staying at his parents' home and his mother was expressing concerns about this mental health. He used illicit drugs and was admitted to the local general hospital in July 2014, because of a drug overdose. By September 2014, in a review with the consultant psychiatrist, Mr M disclosed that his use of illicit drugs had increased over the previous two years. The consultant psychiatrist concluded that Mr M 's mental state had deteriorated as a result of his illicit substance misuse. He did not consistently engage with CMHART for the rest of 2014.

5.29 In March 2015, there were concerns about Mr M 's mental health. He would not allow CMHART into his home and appeared to be under the influence of illicit drugs. By May 2015 he had a new care coordinator (CCO1).[61] In October 2015 Mr M 's father was concerned about his mental state, and CMHART agreed to bring forward the CPA review planned for February 2016 (there is no evidence that this appointment was changed). In November 2015 Mr M said that he was hearing voices.

5.30 Mr M was seen at his parents' home in January 2016, he was hearing voices and had taken amphetamines for five days. Mr M did not attend the CPA in February 2016. The consultant psychiatrist had wanted to discuss restarting clozapine with him and his parents.

5.31 In March 2016, Mr M would not allow staff into his flat. He had not collected his medication since January 2016. A complex case review was held in April 2016. The meeting identified his risks as:

- Potential harm to others.
- Non-compliance with prescribed medication.
- Increased amphetamine use.
- Concerns about his vulnerability, physical health, and housing.

5.32 The CMHART visited Mr M who was unkempt, his flat was a mess and he said that he had been using amphetamines. He had not used amphetamines since moving in with his parents but was experiencing auditory hallucinations' and delusional beliefs.

5.33 The plan from this meeting was for Mr M to be visited weekly by CMHART (in pairs), an appointment was made for the consultant psychiatrist to review Mr M in May 2016 and the associate practitioner was to formulate a plan to manage and minimise Mr M 's risk, with involvement from Mr M 's parents. This was to include a MARE[60] discussion. The associate practitioner had discussed a potential referral with the MARE lead on 14 April 2016, a decision was made not to refer Mr M to MARE because his risks were reduced while he was living with his parents. It was agreed that CMHART could refer back to MARE if there was a change in his risks.

5.34 The day after the complex case review meeting the associate practitioner met with Mr M 's father. His father was frustrated with mental health services. Mr M 's parents had 'had enough'. The associate practitioner and another member of the team visited Mr M that afternoon. Mr M was unkempt, his flat was a mess and he said that he had been using amphetamines. They supported Mr M to buy some food and updated Mr M 's parents following the visit.

5.35 Mr M was advised to self-refer to substance misuse drug services.[61] He did not engage with the service because of a number of issues with appointments and transport. The consultant psychiatrist continued to

[61] *CCO1 was a Band 4 assistant practitioner.*

prescribe olanzapine because he would not accept clozapine.

5.36 Mr M 's mental health had stabilised by the time he was seen in an outpatient appointment on 20 May 2016. He had not used amphetamines since moving in with his parents but was experiencing auditory hallucinations and delusional beliefs. Mr M was advised to self-refer to drug services. The consultant psychiatrist continued to prescribe olanzapine because Mr M would not accept clozapine.

5.37 In October 2016, the associate practitioner completed four visits to Mr M. He was continuing to hear voices, but they were not distressing him, was drinking excessive amounts of alcohol, and was reported to be quite irritable. Mr M was provided with support to complete a housing application to move closer to his parents. He was offered a CPA review meeting with the consultant psychiatrist which he declined.

2017 to April 2018

5.38 In February 2017, Mr M said he was having daily thoughts of suicide but did not have the "bottle" to do anything. The Associate Practitioner said that he did not observe any evidence of psychosis, despite Mr M informing him that he was constantly hearing voices. Mr M was drinking 10 units of alcohol every day and was sporadically abusing substances. He went on holiday to Portugal with his parents which he said he enjoyed. There is no record of his parents' views, and we were told by family later that his behaviour ruined their holiday. During April and May 2017, it was recorded that he was drinking very heavily (20 units per day).

5.39 In March 2018 Mr M failed to attend for his planned outpatient appointment with the CMHART consultant psychiatrist. However, his parents came to the CMHART team base and told the consultant psychiatrist about their concerns for Mr M. They said that he was experiencing paranoid delusions and believed that people were going to kill him, that he was carrying two or three large kitchen knives to protect himself. His neighbour had recently called the police because they were concerned about him. Mr M had also recently had a physical altercation with his brother, and he was drinking heavily and using illicit substances. Furthermore, his medication had been changed, and Mr M was not thought to be taking a therapeutic dose of the new medication, quetiapine.[62] He had reduced the dose he was taking because of side effects.

5.40 The consultant psychiatrist concluded that Mr M was an imminent risk to others and a potential high risk to himself. They did not think that treatment in the community was currently safe or effective and made arrangements for an assessment under the Mental Health Act to be completed. Mr M 's brother also contacted CMHART on the 26 March 2018. He was aware that his parents had been to see the consultant psychiatrist, but he wanted to know for himself what was being done for his brother. There is no record of this call

62 Quetiapine is an antipsychotic medication for the treatment of schizophrenia. https://www.nhs.uk/conditions/psychosis/treatment/

being returned by CMHART staff.

5.41 The MHA assessment was completed on 26 March at Mr M 's home. The assessment was completed with the support of the police under Section 135 MHA. During the assessment Mr M spoke about people trying to break into his flat and kill him. He had a knife on the table (and one in the bedroom) that he allowed the police to remove. He denied recent drug use, and he said that he did not think that his medication was working, but he was agreeable to a hospital admission, and was admitted voluntarily.

5.42 In their assessment the consultant psychiatrist stated that Mr M was most stable when prescribed clozapine, but that he was not willing to accept this. Mr M had stopped taking olanzapine in the past because of the side effects. Their recommendation for the inpatient team was to explore the option of restarting clozapine.

5.43 At the time the assessment was completed a bed was not identified for Mr M, so he was taken to A&E by the police under Section 135 MHA. A bed was then identified on Yewdale ward.

5.44 Mr M was discussed at the ward morning meeting on 27 March 2018. His diagnosis was given as treatment resistant schizophrenia. He was noted to have stopped taking his medication and had paranoid thoughts of conspiracies against him. A formulation meeting identified the reasons for the admission as non-compliance with medication. Mr M recognised that he had been admitted to the ward to change his medication, but he did not want to be on the ward. Medication options were discussed, but he did not want to go back onto olanzapine or clozapine. The treatment plan agreed was to complete a urine drug test, and to prescribe chlordiazepoxide[63] as required and clopixol 20mg three times a day.

5.45 He had some leave with his parents over the next few days. He was discussed at the morning meeting on 5 April 2018, it was noted that he had taken leave without adverse effects and had good insight into his residual schizophrenia symptoms.

5.46 At a medical review on 5 April 2018 it was agreed that Mr M would have overnight leave and return to the ward the next day for a depot. He would then be given leave over the weekend. He was to return to the ward for review after the weekend, and if all well would be given leave until the Thursday. A discharge meeting would be held on the Thursday and he would be discharged from the ward. Mr M 's mother was aware of the plan and was supportive of it.

5.47 Mr M returned to Yewdale ward on 6 April 2018, which he reported had gone well. He was given a test dose of zuclopenthixol 100mg and was given leave over the weekend.

5.48 He phoned Yewdale ward on Saturday 7 April 2018, he wanted to know what

[63] *Chlordiazepoxide is prescribed to help with alcohol withdrawal.* https://www.nhs.uk/live-well/healthy-body/drug-addiction-getting-help/

time he was due back on the ward after the weekend. He said that he had fallen out with his parents and might find it difficult to get back to the ward. He was advised to see how the weekend went and to contact the ward on Monday. Mr M phoned the ward on the Monday; he was unable to get back to the ward because he had no transport. He was told to stay on leave and to return to the ward on the Thursday for the discharge meeting.

5.49 Mr M returned to Yewdale ward on Thursday 12 April 2018 for the discharge meeting and was discharged from the ward. He was given a copy of his discharge plan, contact numbers for CMHART and was told that CMHART would complete his 48-hour post discharge review. Before he left the ward, he was given another depot of zuclopenthixol decanoate 100mg.

April 2018 to January 2019

5.50 Mr M was discharged from Yewdale ward on 12 April 2018. CMHART were notified of the discharge on the 13 April 2018 when the ward contacted the team to ask who would be completing the 48-hour review. The care coordinator (CCO1) was not available for work at this time so the responsibility for doing this was passed to the CMHART duty worker. They spoke to Mr M over the phone on the afternoon of 13 April 2018. Mr M reported that he was doing ok and enquired when his depot was due. The duty worker told Mr M that it was due on the 25 April 2018 and asked him to come to the team base between 10.00 am and 12.00 pm.

5.51 He did not attend for his depot on 25 April 2018, or on the 9 May 2018. There appears to have been an expectation that Mr M would attend the depot clinic, but when he did not attend no-one followed this up.

5.52 Mr M 's mother contacted CMHART on 17 May 2018. She was concerned that he had not received his depot the previous month and was taking other medication. She was also concerned that Mr M had told her he had had no face to face contact with the team since his discharge from Yewdale ward.

5.53 The duty worker spoke to Mr M who confirmed that he had not had a depot since he left hospital and that every few days, he was taking olanzapine and quetiapine left over from previous prescriptions.

5.54 The duty worker was unable to locate the depot prescription. They asked the CMHART consultant psychiatrist to provide another one, which they agreed to do. A prescription was left with the consultant's secretary for signing and if this was available before the end of the day the duty worker was to go to Mr M 's home and administer the depot. If not available, the duty worker would provide the depot the following day. At the end of the day a message was left for Mr M to say that the team would visit on 18 May 2018 to provide him with his depot.

5.55 They also called the family to update them and spoke to Mr M 's father, who was very angry and felt that Mr M had been let down by the team. Information about the family concerns were shared with the Psychosis

Clinical Lead[64] via email.

5.56 At the beginning of the day on the 18 May 2018 the CMHART operational manager made phone calls to Mr M and his parents, but neither of the calls were answered. They were able to leave a message for Mr M asking him to call the team. They were not able to leave a message for his parents.

5.57 Mr M returned the call at 10.00 am and spoke to the CMHART admin support. He said that he had been struggling since his discharge. He wanted to speak to CCO1, but they were not in work and he was told that the duty worker would get in touch with him. When the duty worker spoke to Mr M, he said that he was having some difficult days but that he was managing. He was feeling paranoid about being burgled and said he had been burgled three times in the last three years and had arranged to have security cameras put up. Mr M said he was drinking regularly, and the duty worker noted that during the call he appeared to be under the influence of alcohol. Mr M wanted to know what was happening about his care because CCO1 was not in work. He was told that this would be passed to the Psychosis Clinical Lead for them to formulate a plan.

5.58 The CMHART operational manager and the consultant psychiatrist met with Mr M 's parents on 18 May 2018. They agreed that there had been some confusion about Mr M 's depot following his discharge from hospital. Mr M had received test doses of zuclopenthixol on 12 and 24 April 2018 but had received nothing since. He had been prescribed zuclopenthixol 200mg once a fortnight. The meeting noted that there were indications that Mr M was experiencing some relapse symptoms. Mr M's parents asked the team for support for Mr M and themselves. They wanted a package of care for Mr M and carer's support for themselves. The CMHART operational manager passed Mr M 's parents request to the Psychosis Clinical Lead.

5.59 On 18 May 2018, the team also received a call from the Housing Association. Mr M 's neighbour had complained that Mr M was banging and making a lot of noise in the early hours of the morning, and during the night. This call was discussed with the Psychosis Clinical Lead and passed to the duty worker.

5.60 During the afternoon of 18 May 2018, the Psychosis Clinical Lead, accompanied by another member of CMHART, visited Mr M at home. They administered zuclopenthixol 100mg depot injection. Mr M asked for his depot to be given at home in future because he felt paranoid when he went outside. This was to be discussed with the team.

5.61 The depot zuclopenthixol 100mg was given again at his flat on 1 June 2018. Mr M told CMHART staff that he was using cannabis and amphetamines. He told them that he wanted his prescription to be changed from a depot to oral medication. The CPN agreed that they would discuss this with the doctor.

5.62 When the depot Zuclopenthixol 100mg was given again at his flat on 15 June

[64] *The Psychosis Clinical Lead is the lead clinician and supervisor of the psychosis pathway of care in CMHART.*

2018, Mr M asked for a weekly visit from the team. There was a discussion about him building structure to his week and about him attending the MIND[65] 'drop in' service. Mr M said that he would initially need support to do this and it was agreed that a support time and recovery (STR) worker would be asked to support him the first time he went to the drop-in centre.

5.63 When CMHART visited Mr M on 29 June 2018 to give him his depot he was reluctant but accepted the depot. He said that injections were not effective. Mr M asked for CCO1 to contact him when they returned to work, and that he found weekly sessions with them useful.

5.64 The next time CMHART attempted to visit Mr M was on 20 July 2018. Mr M was not at home and they left a message for Mr M to contact the team to make arrangements for a visit. The team attempted to contact Mr M again on 23 July 2018, without success.

5.65 On 24 July 2018 CMHART completed a home visit. Before the visit, the practitioner checked with the CMHART junior doctor that it was appropriate to provide Mr M with his depot, as it was four weeks since his last depot. Mr M told them that there was no point in leaving messages for him when he did not answer the phone because he did not listen to his messages. He accepted zuclopenthixol decanoate 100mg.

5.66 He was informed that his next injection was due on 10 August 2018 and someone from the team would be in touch to make arrangements for the visit. Mr M told them that he would prefer oral medication and he was told that this would be discussed with whoever was taking over the depot clinic. CMHART noted that his flat smelt strongly of cannabis and he said he was smoking it on a regular basis. They also commented in the notes that there was no evidence of a deterioration in Mr M 's mental health.

5.67 Mr M phoned CCO1 on the 2 August 2018 to cancel the appointment for his depot. He said that he had not slept for three days and did not want a visit. CCO1 visited with a CPN on 3 August 2018 to provide his depot, Mr M was not at home. He was also discharged from the CMHART physical health clinic on 2 August 2018 because he did not attend for his appointment.

5.68 CCO1 visited Mr M with a CPN on 10 August 2018 to provide his depot. They noted that Mr M 's mental health appeared to be stable. They questioned him about why he was not able to come to the depot clinic for his injection. They pointed out to him that he was able to go out to buy food, alcohol and cigarettes and that he needed his medication so he should be able to come to the clinic for his depot.

5.69 CCO1 visited with a CPN on 31 August 2018 to provide his depot. Mr M initially declined the depot but was unable to say why he was refusing; he then did accept the depot. Staff noted that there was no sign of psychosis, but that Mr M was irritable. He said that he was using alcohol daily and was

[65] *MIND is a charity providing mental health support, which provided a regular drop in facility in the local area.* https://www.mind.org.uk/

using cannabis but was not using amphetamines. Mr M asked for a medication review. The next depot was planned for 14 September 2018. It is not clear why this was not administered.

5.70 He was placed on the CMHART waiting list for a medical review on 7 September 2018, having been identified as a 'low priority'.

5.71 CMHART received a phone call from the Liaison & Diversion team in Workington on 21 September 2018. The call was taken by CCO1. The Liaison & Diversion team reported that Mr M had been arrested on 20 September 2018 for alleged ABH, but that he had been released without charge and had declined support from Liaison & Diversion. This was discussed with the CMHART advanced practitioner and it was agreed that CCO1 would assess Mr M 's risk, mental health and substance misuse during the visit planned for that day.

5.72 CCO1 visited Mr M at home later on 21 September 2018 with a CPN to provide his depot. Mr M would not allow them into his flat and was irritable, they were unable to assess his risk, mental health, or substance misuse, or administer the depot. Mr M was asking for a change in his medication and was told he would need a medical review before a change could be made. The plan from the visit was to discuss Mr M at the CMHART daily meeting the following day.

5.73 Mr M was discussed that the CMHART daily meeting on 24 September 2018. It was decided that he would be allocated a new care coordinator (CCO2). The new care coordinator was a qualified social worker. There was also a plan for a phone call to Mr M, but there is no evidence that a phone call was made.

5.74 CMHART received a second call from the Liaison & Diversion team in Workington on 25 September 2018. Mr M had attended the police station and reported that a [named individual] was coming to get him. The Liaison & Diversion team said that Mr M was intoxicated and paranoid, he had said that his head was 'bursting with stress'. A Vulnerable Adults[66] form had been completed.

5.75 Adult Social Care shared the Vulnerable Adults report with CMHART on 26 September 2018. It was sent to the duty worker and CCO1. CCO1 and the new care coordinator were to make arrangements to see Mr M. CCO1 called to let him know that a new care coordinator had been allocated. An appointment was made for both to visit him at home on 4 October 2018. During the call Mr M was told that they would be unable to visit him if he was under the influence of drugs. As planned, CCO1 and the new care coordinator (CCO2) visited his flat on 4 October 2018, but there was no reply. The plan was to contact him the following week.

5.76 CCO1 called Mr M on 8 October 2018, and again there was no reply.

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[66] *Cumbria Constabulary Vulnerable Adults Safeguarding Form.*

Another phone call was made on 30 October 2018, and arrangements were made to visit Mr M later that day to introduce CCO2. CCO1 and CCO2 visited Mr M at home on 30 October 2018. Mr M refused his depot and asked for quetiapine to be prescribed. He said he was drinking alcohol and using cannabis, and in addition he admitted to using other drugs. He said that he was anxious about going out but agreed that he was able to go out to buy alcohol. A kitchen knife was visible next to his television, which he said was there because he was worried about drug dealers breaking into his flat. The plan from this appointment was to make arrangements for a medical review. It was also noted that the next appointment was to be at the team base because Mr M had been agitated and anxious, and there was a knife visible in the room.

5.77 Mr M 's father contacted CMHART on 13 December 2018, saying he had passed his flat and a window was boarded up. Mr M had been refusing to have any contact with his family for some time. CCO2 noted he had no new information to share with Mr M 's father, he was declining his depot but would attend a medical review if one were arranged. The plan following the call was for CCO2 to make contact with Mr M and arrange to see him, and to provide Mr M 's father with an update.

5.78 CCO2 updated the waiting list request for Mr M on 17 December 2018 and identified that he was at risk of relapse and requested a medication review. The waiting list entry was revised again on 10 January 2019 and Mr M remained a 'low priority'.

5.79 On 15 January 2019 Mr M 's father came to the team base and was seen by the duty worker. He told the duty worker that Mr M had walked from Workington to Dearham in the middle of the night. His father was concerned about him and said Mr M was anxious and had not had his depot since 31 August 2018. Mr M 's father did not think that he was a risk to himself or others, and he was sleeping at his parents. The duty worker was to get advice from the CMHART junior doctor about giving Mr M his depot, because he had not had one for more than four months. If the doctor agreed to a depot being given the CMHART duty worker[67] was to visit Mr M 's parents' home and give the depot later that day. The duty worker would also speak to CCO2 about a review for Mr M. The duty worker was a Registered Learning Disability Nurse (SN1).

5.80 SN1 agreed to see Mr M at the team base at 3.00 pm on 16 January 2019. The duty worker discussed with the CMHART junior doctor the possibility of giving Mr M a depot that day. The CMHART junior doctor reviewed the depot prescription and the progress notes. They concluded that it was not possible to provide the depot because of the length of time since the last one. They suggested that the appointment with SN1 concentrated on current symptoms, alcohol, and drug use, to determine how urgent the need was for a medical review. If an urgent medical review were required one could be given for the following week.

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[67] *The duty system is where there is a member of CMHART staff allocated to manage day to day enquiries.*

5.81 Mr M was seen at the team base on 16 January 2019 by SN1, he was accompanied to the appointment by his father. Mr M was anxious and restless during the appointment. He said that he wanted help, was willing to attend a medical review and wanted to start taking medication again. He said that he had been hearing voices and experiencing hallucinations, and that he had been using alcohol and cannabis to try and manage this, although he said that he had reduced his alcohol intake in the last two to three days. Mr M's father was concerned that he was not sleeping, and he was at risk of relapse in his mental health.

5.82 SN1 arranged a medical review appointment for Mr M at 10.00 am on 24 January 2019 at the team base.

6. Analysis of mental health care and treatment

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

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

6.2 Each of these areas will be examined using the subheadings of the terms of reference. We have however developed further detailed headings that have emerged following our analysis of the issues. These are:

- Medication management.
- Family involvement and carer support.
- Inpatient admission and discharge.
- Safeguarding.
- Risk assessment.
- Medical reviews.
- CMHART management.

Specific terms of reference

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

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

Care and treatment plans

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

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

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

6.5 Mr M had the following diagnosis:

- F20.0 Paranoid Schizophrenia.
- F19.1 Harmful use of amphetamine and cannabis.
- F15.2 Dependency of Stimulants (amphetamine).

6.6 In July 2017 Mr M was being managed by CMHART under the Care Programme Approach (CPA). Although he was living at his parent's address for a period in 2017, he had retained his flat. He was cared for under CPA, as the Trust policy states:

'An individual deemed to have complex needs, a higher risk profile and/or requiring multi-agency input should be placed on CPA'.[68]

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

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

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

6.9 The care coordinator is described as pivotal to the success of CPA and the responsibilities of the role include:

- 'Complete a holistic assessment of the service user's needs including risk.
- To ensure the prompt and appropriate circulation of risk information, care plans etc to those who need to know.
- To identify strengths of service users, and those of their Carers, where appropriate.
- To collaborate with service users, carers, and others as appropriate, in developing and implementing a risk management plan for the service user.

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

- To collaborate with service users, carers, and others as appropriate, in developing a care plan for the service user in line with the Care and Treatment Pathways.
- Ensure high quality care is delivered in accordance with care pathways relevant for the service user, his or her condition and adapted in such ways that they provide consistent personalised high-quality care.
- To facilitate timely access to help, advice and support of other agencies including adult social care (ASC), housing and educational/training institutions.
- To schedule and convene timely reviews of care plans, and urgent reviews as required.
- To complete relevant CPA/care management documentation as required.
- To provide reports to MHA Managers Appeals and MHRT as appropriate in line with agreement with Adult Social Care'.

6.10 Mr M had an allocated care coordinator (CCO1). CCO1 was a Band 4 Assistant Practitioner, and as such a member of staff with no professional registration. The CPA policy does not explicitly state that Assistant Practitioners can be care coordinators, but it is unclear in the Policy, as stated: 'Assistant Practitioners… Have an ongoing responsibility to identify their own training needs in conjunction with their manager, job description and service specification. This must be acknowledged within the appraisal system. The registered practitioner has a responsibility to support this process in line with their professional accountability'.

6.11 We were told at interview that Assistant Practitioners should receive regular supervision from a registered practitioner. CCO1 had in fact known Mr M for over 15 years, having worked with him before, in the AOT service. He had got to know Mr M 's parents, and his mother in particular.

6.12 There was no evidence of regular supervision provided. In our view it is inappropriate to expect this level of responsibility for patient care to be carried by an Assistant Practitioner, especially where there is medication including depot administration involved. We would have recommended that this practice be stopped immediately but have been informed that the new Trust has stopped this practice.

6.13 Between February and July 2018 CCO1 was absent from work. An interim care coordinator was not identified, and Mr M was managed through the CMHART duty system. When CCO1 returned to work there was a review of his caseload. Mr M was to be allocated a new care coordinator and until this happened in October 2018, he continued to be managed through the CMHART duty system.

6.14 In the 18 months prior to the homicide no CPA review was completed for Mr M and there was no holistic assessment of his needs. (The issue of risk is discussed in detail in Section 6).

6.15 A complex case review was held in July 2017, although Mr M and his parents were not invited to attend this. The purpose of this review was to determine, 'What level of contact CMHART has with Mr M? What treatment should CMHART be offering?'. This review was held in line with the Trust Standard Operating Policy for the Management of Clinical Enablement Structures in CMHARTs (July 2016). However, it is unclear to us why this complex case review was held.

6.16 The meeting was attended by the team consultant psychiatrist, the Psychosis Clinical Lead, and other members of CMHART. CCO1 provided the meeting with information about Mr M. There is a record of the meeting and the subsequent plan in Mr M 's clinical notes, but the information provided to the meeting and the rationale for the plan is not included in this record. At interview, the staff were not able to provide us with any additional information about this meeting.

6.17 The outcome from this review was that Mr M should be moved to 'standard care',[69] be offered an occupational therapy assessment 'Recovery Through Activity', and a relapse prevention plan was to be developed with Mr M and his parents. Once these actions had been completed, Mr M was to be offered a review every three months to review his risk and treatment, and to test his engagement. Mr M and his parents were not invited, as it was a professionals meeting.

6.18 The plan agreed at the complex case review was not completed, and Mr M did not accept a referral to the OT or to 'Recovery Through Activity'. CCO1 asked him to start a relapse prevention plan with his parents, but there was no evidence that this was completed, and he was not formally transferred onto standard care. There is no evidence that there were any further CPA reviews or CPA care plans completed for Mr M.

6.19 There is a Policy expectation that the care coordinator will complete a holistic assessment of the service users' needs including risk.

6.20 In addition, there is a Policy expectation that care coordinators will collaborate with service users, and carers in developing a care plan for the service user in line with the care and treatment pathways. We have not seen any evidence that Mr M or his parents were involved in the development of care plans for Mr M in the 18 months prior to the incident. Mr M was asked to start to complete a relapse recovery plan at the end of 2017, but there is no evidence of its completion or CCO1 working with Mr M and his parents to develop a plan.

6.21 The Policy requires that care plans are subject to regular review and where necessary changes made to the plan. It states that care plans should be subject to review at a minimum of six-month intervals, and/or when there are changes in circumstances which might require a review. There were a number of occasions in the 18 months prior to the incident when we would have expected to see a holistic review of Mr M 's care needs and a care plan:

[69] *Standard care is for those patients who do not have complex mental health needs.*

- In November 2017 when he had stopped taking olanzapine, we would have expected a care plan to have been agreed with Mr M. There should have been a care plan that outlined how Mr M was to be monitored in the five weeks he was titrated onto quetiapine, and how his compliance with prescribed medication would be monitored after this.
- In January 2018 when he returned to live independently after living with his parents for two years. Furthermore, it was known that he had started to use illicit substances having not used them while living with his parents and he reported he was drinking heavily.
- In April 2018 when Mr M was discharged from Yewdale ward on a depot medication. CMHART did not complete a CPA review for Mr M following this discharge to reflect this change in medication, how it would be provided and monitored.
- In May 2018 Mr M 's parents requested an assessment of Mr M 's needs and for a care package to be put in place. They also requested an assessment of their needs as his carers. The CMHART operational manager and Consultant Psychiatrist met with Mr M 's parents and said that they would pass the request to the CMHART Psychosis Lead. At this time CCO1 was absent from work and CMHART did not complete an assessment or put a care package in place.
- In August 2018 when Mr M declined to accept the depot and requested a medical review.
- In October 2018 after the police contacts and when a new care coordinator (CCO2) was allocated.

6.22 When CCO1 returned to work in July 2018 it was agreed that his caseload would be reviewed and there was a plan to allocate Mr M to another care coordinator. Mr M was managed through the CMHART duty system until he was allocated to CCO2 in October 2018. At this time Mr M was prescribed a depot injection of zuclopenthixol decanoate. The Medicines Policy, December 2016, requires teams to 'Ensure that the ward or community team has robust continuity arrangements in place so that all medicines related tasks will be continued in the event of staff absence or sickness (e.g. continuity of support for clozapine tests or collection, and depot administrations, and similar tasks)'.

6.23 The CPA Policy expectation is that prompt and appropriate circulation of risk information takes place, and care plans are shared with all those who need to know. Within the CPA policy there is an identified structure for monitoring compliance with the Policy. The aspects of 'compliance with CPA reviews' and of 'data quality monitoring of CPA reviews' should be monitored and reported upon via a performance monitoring dashboard, and data quality audits.

6.24 Within the CPA policy there is an identified structure for monitoring compliance with the Policy. The aspects of 'compliance with CPA reviews' and of 'data quality monitoring of CPA reviews' should be monitored and

reported upon via a performance monitoring dashboard, and data quality audits. This is discussed further in the 'CMHART management' section (from paragraph 6.125).

6.25 CMHART did complete regular physical health checks for Mr M and shared information with his GP in line with the Shared Care Policy, and the GP was provided with clinic letters following medical reviews and discharge summaries when he was discharged from Yewdale ward.

6.26 NICE guidance[70] for treatment of psychosis provides evidence-based guidance on the following best practice elements of treatment:

- Service user experience.
- Physical health.
- Support for carers.
- Peer support and self-management.
- First episode psychosis.
- Subsequent acute episodes of psychosis or schizophrenia and referral in crisis, and behaviour that challenges.
- Psychological interventions.
- Pharmacological interventions.
- Using depot/long-acting injectable antipsychotic medication.
- Employment, education, and occupational activities.

6.27 We have benchmarked Mr M's care in relation to these standards in the table at Appendix E. The results of this benchmarking show that there were no psychological interventions offered, no carers support or family interventions (discussed below), employment, education or occupation, or robust physical health support. Medication management is discussed in more detail in the next section.

Finding 5 - Trust care and treatment

The CPA policy was not followed with respect to care coordinator provision, care planning and reviews, and Trust systems did not identify or address these deviations from expected policy within CMHART.

Assistant Practitioners were assigned to take on the role of care coordinators within the original Trust. We have not made a recommendation that this should stop, because the new Trust has confirmed that this is no longer accepted practice.

There was no care coordinator cover provided for a six-month period in 2018. There was no evidence of an evidence-based treatment plan that was in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management

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

Recommendation 7
The Trust must ensure that evidence-based treatment plans are in place, that are in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management.

Recommendation 8
The Trust must develop systems that ensure there is consistent monitoring and maintenance of expected standards within the CPA Policy.

Medication management

6.28 In the time that Mr M has been under the care of mental health services he has been prescribed a range of anti-psychotic medication to help him manage his symptoms. He was initially prescribed depot medication, by 1998 he was being prescribed flupentixol decanoate[71]every four weeks, along with olanzapine[72] 10mg daily, promethazine[73] 10mg and haloperidol[74] 5-10mg PRN. In 2006 clozapine was discussed with Mr M because he was experiencing some side effects from the depot and in September 2007, he began to be titrated onto clozapine.[75] Mr M continued to be prescribed clozapine.

6.29 Mr M was prescribed clozapine from 2006 to 2012. Clozapine is the only effective drug for treatment-resistant schizophrenia. A patient whose schizophrenic illness has not responded fully to treatment with other antipsychotic drugs, may be considered 'treatment resistant'. Treatment resistance occurs in about a third of people with schizophrenia. The latest guidance[76] from NICE in 2014 stated that clozapine should be considered for patients who had failed to respond adequately to separate trials of two other antipsychotic drugs. Clozapine is unique in that a so called 'therapeutic threshold' has been identified with a specific level of the drug in the patient's blood. This means that if a patient does not appear to be responding to treatment with clozapine, the level in their blood can be measured to ensure that a sufficient dose has been prescribed.

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[71] *A first-generation anti-psychotic prescribed for maintenance in schizophrenia and other psychoses. The usual maintenance dose 50mg every 4 weeks to 300mg every 2 weeks; maximum 400mg per week.* https://bnf.nice.org.uk/drug/flupentixol-decanoate.html

[72] *An atypical antipsychotic primarily used to treat schizophrenia and bipolar disorder. For schizophrenia, it can be used for both new onset disease and long-term maintenance. 10mg daily, adjusted according to response, usual dose 5–20mg daily, doses greater than 10mg daily only after reassessment.* https://bnf.nice.org.uk/drug/olanzapine.html

[73] *Promethazine is a first-generation antihistamine. It is used to treat allergies, trouble sleeping, and nausea. It may help with some symptoms associated with the common cold. It may also be used for sedating people who are agitated or anxious. The does for an adult is 10–20mg 2–3 times a day.* https://bnf.nice.org.uk/drug/promethazine-hydrochloride.html

[74] *Haloperidol is a typical antipsychotic medication used in the treatment of schizophrenia, Adult dose 2–10 mg daily in 1–2 divided doses; usual dose 2–4mg daily, in first-episode schizophrenia, up to 10 mg daily, in multiple-episode schizophrenia, dose adjusted according to response at intervals of 1–7 days. Individual benefit-risk should be assessed when considering doses above 10mg daily: maximum 20mg per day.* https://bnf.nice.org.uk/drug/haloperidol.html

[75] *Clozapine is an atypical antipsychotic medication. It is mainly used for schizophrenia that does not improve following the use of other antipsychotic medications. In those with schizophrenia and schizoaffective disorder It is more effective than typical antipsychotics, particularly in those who are treatment resistant. The usual dose following titration 200–450mg daily, max.900mg per day,* https://bnf.nice.org.uk/drug/clozapine.html

[76] *Psychosis and schizophrenia in adults: prevention and management.* https://www.nice.org.uk/guidance/cg178

6.30 Unfortunately, clozapine has a number of problematic side-effects, principally neutropenia,[77] which requires long term monitoring of the patient's white blood cell count. If the blood test shows a low white blood cell count (known as a 'red result'), then it is advised that they discontinue treatment with clozapine. However, sudden discontinuation of clozapine is very often followed by rebound psychosis, which can be severe and very difficult to treat. This can also be complicated by cholinergic rebound,[78] which can cause nausea, vomiting, diarrhoea, headache, sweating, restlessness, and agitation. This is because clozapine has a specific effect on the cholinergic system in the body. Therefore, clozapine discontinuation should take place gradually, unless this cannot be avoided (for example, if clozapine has to be stopped abruptly because there is neutropenia).

6.31 In 2009 Mr M was complaining of side effects from the clozapine, especially sedation and in September 2009 his prescribed dose was reduced. His dose continued to be reduced during 2010 and 2011. At a medical review in November 2012 he was described as being 'determined' to get his prescribed medication changed from clozapine to olanzapine. He said that he would stop taking it the following month if his prescription was not changed, so the team agreed to discontinue the clozapine and titrate him onto olanzapine.

6.32 During 2013 Mr M experienced a deterioration in his mental health and by the October had stopped taking the olanzapine. He started to take the prescribed olanzapine again and it continued to be prescribed by his GP under a 'Shared Care Agreement'. In November 2017 he told CCO1 that he had not been taking the olanzapine for three months. He said that he continued to hear voices when he was taking it. CCO1 contacted medicines management at the GP surgery and asked them to stop prescribing the olanzapine and they arranged an urgent medical review for 23 November 2017.

6.33 At the medical review it was agreed not to restart Mr M on olanzapine and Mr M would be prescribed quetiapine.[79] A fax was sent to his GP confirming that the olanzapine was to be stopped and asking them to titrate him onto quetiapine, the plan was:

- Week 1 - 25mg.
- Week 2 - 50mg (change to quetiapine MR to minimise sedation).
- Week 3 - 100mg.
- Week 4 - 150mg.

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[77] *Neutropenia means having a very low number of neutrophils in the blood. Neutrophils are white blood cells, which are normally found in the blood in large numbers. They help fight infection, particularly bacterial and fungal infections.* https://www.nhs.uk/conditions/low-white-blood-cell-count/

[78] *Cholinergic rebound syndrome is induced in susceptible patients after an abrupt discontinuation of a drug that blocks muscarinic acetylcholine receptors. Its central component is characterized by agitation, confusion, psychosis, anxiety, insomnia, hypersalivation and extrapyramidal manifestations.*

[79] *Quetiapine is an atypical antipsychotic medication used for the treatment of schizophrenia, bipolar disorder, and major depressive disorder. For Adult. 25mg twice daily for day 1, then 50 mg twice daily for day 2, then 100mg twice daily for day 3, then 150mg twice daily for day 4, then, adjusted according to response, usual dose 300–450mg daily in 2 divided doses.* https://bnf.nice.org.uk/drug/quetiapine.html

- Week 5 - 200mg.

6.34 Mr M was monitored by CCO1 during November and December 2017, and January 2018. CCO1 completed a Glasgow Antipsychotic Side-effects Scale[80] (GASS) with Mr M on 4 December 2017. This resulted in a score of six, a score of less than 21 indicates that side-effects are absent or mild.

6.35 He had a physical health check completed at the CMHART physical health clinic on 8 December 2017 and the results were shared with his GP. The GP was told that Mr M had given a high blood pressure reading and he had been advised to take more exercise and seriously consider reducing his alcohol intake and stop smoking.

6.36 CCO1 continued to provide Mr M with support in the community, seeing him approximately every three weeks. In December 2017 Mr M disclosed to CCO1 that he had not been taking the prescribed olanzapine. CCO1 responded promptly, made contact with the GP to stop the prescription for the olanzapine and made an appointment for an urgent medical review. He was prescribed quetiapine at the medical review in November 2017, but there is no evidence that there was a plan in place to monitor his compliance with the prescribed quetiapine.

6.37 Mr M was seen at his parents' home on 23 January 2018 by CCO1. During a telephone call on 15 February 2018 Mr M told CCO1 that his mental state was stable but that he had been experiencing some side effects since his dose of quetiapine had been 200mg daily. CCO1 was absent from work from mid-February 2018 until July 2018 and Mr M 's care was managed solely through the CMHART duty system.

6.38 On 12 March 2018 Mr M told the duty worker that he did not think that the quetiapine was working for him and he was concerned that he would end up on Yewdale ward. On 19 March 2018, his mother contacted CMHART requesting an urgent medical review for Mr M. An appointment was made for him for the 26 March 2018, which he did not attend, but his parents did. Based on the information they provided, arrangements were made for the assessment and subsequent admission to Yewdale ward.

6.39 As part of the assessment the consultant psychiatrist considered the medication options. They identified that he had stopped taking olanzapine the previous year because of side effects so Mr M was unlikely to accept risperidone[81] or amisulpride.[82] They noted that Mr M 's mental health was most stable when he was prescribed and compliant with clozapine. The consultant psychiatrist recommended that the option of prescribing clozapine be explored with him during the admission.

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[80] *The Glasgow Antipsychotic Side-effect Scale (GASS) is an easy to use self-reporting questionnaire aimed at identifying the side effects of antipsychotic medication. It consists of 22 questions with points assigned based on answers given by the patient.* https://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/

[81] *Risperidone is an atypical antipsychotic. It is used to treat schizophrenia, bipolar disorder, and irritability associated with autism. It is taken either by mouth or by injection into a muscle.* https://bnf.nice.org.uk/drug/risperidone.html

[82] *Amisulpride is an antipsychotic medication used to treat schizophrenia and acute psychotic episodes.* https://bnf.nice.org.uk/drug/amisulpride.html

6.40 The ward pharmacist completed a medicines reconciliation for Mr M following his admission to Yewdale ward. This confirmed that his prescribed medication was quetiapine 200mg, lansoprazole[83] 15mg and simvastatin 40mg.[84] When Mr M went on leave on 6 April 2018, he was given a leave prescription for six tablets of zopiclone[85] 7.5mg, in addition to clopixol[88] 20mg, lansoprazole 15mg and simvastatin 40mg.

6.41 The preliminary discharge summary and prescription sent to Mr M 's GP when he was discharged from Yewdale ward on 12 April 2018 identified that the quetiapine had been stopped and his prescribed medication was clopixol 20mg TDS, lansoprazole 15mg and simvastatin 40mg. It went on to state that while an inpatient Mr M had received two depot injections, on 6 April 2018 and 12 April 2018 zuclopenthixol decanoate 100mg. It then stated that Mr M would require an injection of zuclopenthixol decanoate 200mg every two weeks starting on 26 April 2018. However, the full discharge summary dated 15 May 2018 does not reference the clopixol 20mg TDS and states that the injection should be zuclopenthixol decanoate 100mg every two weeks.

6.42 CMHART wrote to Mr M on 24 July 2018 informing that his depot would continue to be provided at his home, but the day would change to a Friday afternoon and his next depot was due on 10 August 2018. This was the last depot administered, and the system for ensuring that depot medication was administered was ineffective.

6.43 He did not attend for a physical health check on 2 August 2018, his GP was informed that a physical health screening had not been completed as per the 'Shared Care Guidelines'.

Finding 6 - Trust medication management

The administration of depot medication was not recorded in the electronic clinical records.

Depot medication was missed, and there was no robust system for ensuring these were administered at the correct times or following up missed injections. This resulted in Mr M being unmedicated from August 2018 to January 2019.

Mr M was not stabilised on depot medication before discharge from Yewdale ward, West Cumberland Hospital.

Recommendation 9
The Trust must provide assurance that there is a system in place that ensures all patients receive depot medication as prescribed, and that records are made both in the medication chart and the electronic clinical record.

Inpatient admission, treatment, and discharge

[83] *Lansoprazole is a medication which reduces stomach acid.* https://bnf.nice.org.uk/drug/lansoprazole.html
[84] *Simvastatin is a lipid-lowering medication. It is used along with exercise, diet, and weight loss to decrease elevated lipid levels. It is also used to decrease the risk of heart problems in those at high risk.* https://bnf.nice.org.uk/drug/simvastatin.html
[85] *Zopiclone is a type of sleeping pill that can be taken to treat insomnia.* https://www.nhs.uk/medicines/zopiclone/

6.44 In March 2018, the CMHART Consultant Psychiatrist had identified the need for an admission to complete a medication review and explore the option to recommencing clozapine with Mr M. An appointment was made for him for the 26 March 2018, which he did not attend, but his parents did. Based on the information they provided, arrangements were made for an assessment and subsequent admission to Yewdale ward on 26 March 2018.

6.45 On the 27 March 2018 a formulation meeting was held for Mr M, in line with the Transfer and Discharge of Patients within and from Community Hospital/Step up Step Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust (version 2) that requires a patient to have a review within 72 hours of their admission. At this meeting, the team explored the options of clozapine with Mr M on 27 March 2018, they discussed this with him again on 2 April 2018. It was Mr M 's view that he had tried a number of different anti-psychotics and nothing had stopped his hallucinations completely, and that this was something he would have to live with. Furthermore, he had experienced palpitations when prescribed clozapine in the past.

6.46 Mr M was initially prescribed clopixol 20mg and he was compliant with this. It is unclear why on 6 April 2018 he was given a test dose of depot zuclopenthixol decanoate 100mg. We were unable to see any evidence of a discussion with Mr M about the option of a depot. Furthermore, this option was not discussed with the CMHART Consultant Psychiatrist or the CMHART Psychosis Lead.

6.47 During the formulation meeting Mr M said he started to hear voices again when he took amphetamines again. He was offered but declined any medication to help him manage any withdrawal symptoms he might experience.

6.48 The Trust Protocol for the Management of Informal Patient's Leave from Adult Mental Health In-patient Wards (June 2017) identifies leave as, *'Leave is described as any agreed or authorised period of absence from the ward and is an essential part of an individual patient's treatment plan and recovery*'.

6.49 The Protocol requires the ward to consider the potential risks to the patient and/or others of off-ward activities including leave to their home as part of a comprehensive risk assessment. This risk assessment should consider relevant information from others, e.g. family, and the social circumstances of the patient.

6.50 It also requires a pre-leave assessment form to be completed, this should have been informed by the comprehensive risk assessment and reviewed by the ward multi-disciplinary team (MDT) when deciding about home leave.

6.51 We have concluded that the management of Mr M's leave from the ward was unstructured and did not consider risk to himself and others. More importantly changes to his risk profile were not considered, when he reported that he had fallen out with this parents' over the weekend. The ward did not

ask for any detail about what had happened, contact his parents for confirmation of the situation or ask CMHART to complete a visit. The ward agreed that he did not need to return to the ward on the Monday but could remain on leave until the Thursday, returning for his discharge ward round.

6.52 The document 'Transfer and Discharge of Patients within and from Community Hospital/Step up Step Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust' describes 'discharge planning as a continuous process which begins on admission and continues until the patient is safely discharged from the ward.' It requires the ward to liaise with the care coordinator who should play a key role within any in-patient episode of care. It also requires 'Arrangements for discharge will be negotiated and agreed with everyone likely to be concerned with the patient's aftercare by the responsible MDT.' There is also a requirement that when appropriate and practicable family/carers are fully involved in the discharge and aftercare plan.

6.53 Yewdale ward did not liaise with CMHART during Mr M 's admission, or about his discharge. CMHART were not invited to attend any of the MDT meetings/ward rounds for Mr M, nor was there any discussion with CMHART or the CMHART Consultant Psychiatrist about Mr M being prescribed a depot medication.

6.54 Yewdale ward did notify CMHART of his discharge, in an email sent to the CMHART Psychosis Lead and the generic team email address requesting that the team complete a 48-hour review. Mr M was told that CMHART was aware of his discharge and he was given a copy of his discharge plan and told to make arrangements with CMHART for the depot that was due on 26 April 2018.

6.55 We were told at interview that it was the view of the ward that Mr M had a history of short admissions as a result of his amphetamine use and that he was 'usually' discharged once his mental health had stabilised. This view is not supported by Mr M 's admission history, and we believe that this mistaken view may have influenced the decisions made about Mr M and his management.

6.56 At interview, we were told that there was no admission/discharge policy in place in April 2018.

Finding 7 - Trust inpatient management

Yewdale ward held the belief that Mr M 's admission was as a result of his substance misuse and that once he had detoxified his mental health issues would resolve themselves.

Yewdale ward did not manage Mr M 's admission in line with the Transfer and Discharge of Patients within and from Community Hospital/Step-up Step-Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust.

There was lack of continuity in care planning, admission, and

discharge between Yewdale ward and CMHART. There was no liaison between the ward, CMHART or his family to plan and agree Mr M's discharge plan.

There was poor communication between the ward and CMHART following discharge.

Risk management on Yewdale ward did not take Mr M's risk assessment into consideration. Leave was unplanned and unstructured, lacking curiosity about his social and family circumstances. This resulted in minimal time actually spent on the ward, which did not allow time for the treating team to get to know him or make contact with his family and assess the situation.

Yewdale ward had no admission and discharge Policy at the time.

Recommendation 10
The Trust must ensure that there is a comprehensive admission and discharge policy for Yewdale ward which includes care planning, risk management and communication with community mental health teams and family/carers.

Family involvement and carer support

"Examine the effectiveness of the service user's care plan including the involvement of the service user and the family. Comment on how the family's views and concerns were addressed."

6.57 The CPA Policy expectation is to 'collaborate with service users and carers in developing a care plan for the service user in line with the care and treatment pathways'. We have not seen any evidence that Mr M or his parents were involved in the development of care plans for Mr M in the 18 months prior to the incident.

6.58 There was a complex case review meeting in July 2017 which did not involve either Mr M or his parents, and neither were involved in the subsequent plan. Mr M was asked to start a relapse recovery plan at the end of 2017 but there is no evidence of its completion, or of CCO1 working with Mr M and his parents to develop a plan.

6.59 CCO1 continued to provide Mr M with support in the community, seeing him approximately every three weeks. In December 2017 Mr M disclosed to CCO1 that he had not been taking the prescribed olanzapine. CCO1 responded promptly, made contact with the GP to stop the prescription for the olanzapine and made an appointment for an urgent medical review. He was prescribed quetiapine at the medical review, but there is no evidence that there was a plan in place to monitor his compliance with the prescribed quetiapine.

6.60 On the 18 May 2018 Mr M's parents requested an assessment of his needs and for a care package to be put in place. At this time CCO1 was absent

from work and CMHART did not complete an assessment or put a care package in place. He continued to be managed through the CMHART duty system, with staff going out to provide him with his depot.

6.61 There was no team response to this request. CCO1 was absent from work mid-February 2018 until July 2018 and Mr M's care was managed through the duty system during this time.

6.62 NICE guidance for psychosis and schizophrenia in adults: prevention and management[86] advises that carers, relatives, and friends of people with psychosis and schizophrenia are important both in the process of assessment and engagement, and in the long-term successful delivery of effective treatments.

6.63 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.

6.64 In our view, psychosocial education should have been provided for Mr M and his parents in understanding the nature of his diagnosis, how his family could support him, what could be expected in terms of recovery, and how medication may affect him.

6.65 The Trust CPA Policy states that 'Carers form a vital part of the support required to aid a person's recovery. Their own needs will be recognized and directed for assessment through Adult Social Care in accordance with the Care Act 2014'.

6.66 We have not found any evidence that referrals for carer's needs were forwarded for assessment, neither did we find any structures used to record any referrals for carers assessments.

[86] *Psychosis and schizophrenia in adults: prevention and management Clinical guideline [CG178]. Published date: February 2014.* https://www.nice.org.uk/guidance/cg178/chapter/Introduction

Finding 8 - Trust family involvement

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

The family was not involved in care planning for Mr M, despite their requests to be involved and informed.

There were no carer's assessments requested or arranged for his parents, despite them specifically requesting this.

Risk management considerations were not applied to his family.

Recommendation 11
The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment.

Recommendation 12
The Trust must ensure that referrals for carer's assessments are routinely part of care planning and risk assessment.

Safeguarding

"Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon. Review the Trust's assessment of vulnerable carers, who are known to be caring for adults with mental health issues."

6.67 There were three adult safeguarding referrals raised in relation to Mr M.

6.68 On 24 July 2014, the police were called by a neighbour who expressed concerns about Mr M's mental health and his potential to harm himself. His dog had been barking all night. An ambulance was called due to his presentation, and he was conveyed to hospital. Mr M told police he had consumed 'speed'. A vulnerable adult referral form was completed on the same day as the reported incident and sent to the local authority.

6.69 On 26 March 2018, a different neighbour called into Workington police station with concerns about Mr M's mental health. She had got up in the morning and seen he had posted several pieces of paper through her letterbox with handwritten notes on which did not make much sense. There were comments like '*1.8 million'*. '*My solicitor says its illegal*'. '*[Brother's name] I'm not bad you know'. 'Google my late grandma'*, and several more. The neighbour did not feel threatened but was concerned for Mr M's mental welfare. She said that he was using alcohol/drugs a lot lately. She said he also kept sticking notes in his window and had said to her that he thinks someone is recording him. When she had seen him the previous day, he also made a comment to her that he feels like 'slitting his wrists'.

6.70 The police called his parents and brother, and also contacted the single point of access for local mental health services. A vulnerable adults safeguarding report was completed and shared with the local authority on 26 March 2018.

6.71 On 19 September 2018 police were called by Mr M after an alleged assault by his neighbour. This was part of a dispute over Mr M 's dog and having drug dealers visiting. Late that night Mr M contacted the police by telephone reporting that his neighbour had entered his flat. He had been there several times that night making threats to life. When his neighbour came into Mr M 's flat, he gave him a 'hiding' and his neighbour left bleeding. When police attended the neighbour said that Mr M had assaulted him and threatened him with a knife. Mr M was arrested for actual bodily harm, but later released with no further action, after the neighbour declined to pursue matters.

6.72 A vulnerable adults safeguarding report was completed and shared with the local authority. All three concerns were raised by the police and shared with the local authority in accordance with local procedures.

6.73 The vulnerable adult's referral form asks the following questions, and we have included the responses:

- Has consent been obtained from the referred person to share information? Yes
- The person referred has needs for care and support from the local authority (whether or not these are being met)? No
- The person is in need of care or support services but does not appear to be currently at risk of suffering abuse or neglect? No
- The person appears to have mental health issues and is not currently receiving a service? No
- The person is open to services and this is for information only (Mental Health Team and GP)? Yes

6.74 It appears that all the referrals raised by the police were 'information only' concerns regarding Mr M 's mental health, therefore there were no adult safeguarding concerns formally raised in relation to Mr M.

6.75 The Care Act 2014 defines an 'adult at risk' as someone over the age of 18 who:

- has needs for care and support (whether or not the local authority is meeting any of those needs);
- is experiencing, or is at risk of, abuse or neglect; and
- as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of, abuse or neglect.

6.76 Whilst Mr M had care and support needs in relation to his mental health there is nothing to suggest that he was experiencing abuse or neglect or that he was not able to protect himself from abuse or neglect as a result of his care and support needs. It is clear that the police considered that they had passed their concerns appropriately to mental health services.

6.77 There were no safeguarding alerts raised in relation to Annie. The judge at Mr M 's trial referred to her as a 'vulnerable woman'. This appears to be a general comment rather than an opinion based on a considered assessment of the situation.

6.78 There is nothing in her history to suggest that Annie had any care and support needs, therefore she would not have met the first criteria of adult safeguarding. The family were evidently exposed to verbal and physical violence from Mr M however this should have either been managed via MAPPA/MARE or via care planning, not by adult safeguarding.

6.79 The internal independent report refers to a 'high safeguarding reporting threshold' by CMHART. We have not found any evidence to support this statement, and there is nothing to suggest that Mr M or Annie would have met the statutory threshold for adult safeguarding. The report also goes on to state that there is 'No evidence of specialist safeguarding advice being sought to provide advice in managing risk/presenting behaviours of the patient'. Whilst the Trust safeguarding team may have been able to advise, this case would not meet the criteria for adult safeguarding.

6.80 In our view the Trust safeguarding service is not best placed to advise on managing risk/presenting behaviours of the patient. We would have expected the clinical team managing Mr M 's care to have the appropriate skills and plans to manage risk and presenting behaviours.

6.81 All referrals were raised with the local authority as a result of deterioration in Mr M 's mental health, and the outcome of referrals resulted in mental health assessments.

Finding 9 - Safeguarding

There is no evidence to suggest that Mr M or Annie should have been considered as an adult at risk in accordance with the Care Act 2014.

We conclude that there were no missed opportunities in relation to adult safeguarding. However, we acknowledge that the family felt that Mr M was a risk to them and described how they tried to manage this within the family.

Risk assessment

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

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

6.82 The Trust used an external clinical risk assessment tool called 'GRiST'.

6.83 The egrist.org website defines GRiST as 'a web-based decision support

system designed to help practitioners assess and manage risks associated with mental health problems, including suicide, self-harm, self-neglect, vulnerability, and harm to others'.[87]

6.84 The website states 'GRiST helps mental health practitioners, service users, and carers detect and explain risks associated with mental-health problems to reduce suicides, self-harming, neglect, and violence'.

6.85 In 2013, it was noted that GRiST was used in three NHS mental health services (including CPFT). In their report on the assessment of risk in mental health organisations in 2018, NCISH[88] found that out of 85 NHS mental health services, four used GRiST. Therefore, despite it being in existence since 2000, it has not been widely adopted by mental health services.

6.86 In April 2016, CCO1 had taken advice from the Trust Multi-Agency Risk Evaluation (MARE) lead about making a referral to MARE for Mr M in April 2016. The advice was that while Mr M was living with his parents his risks were reduced but should anything change a referral could be made.

6.87 The MARE framework applies to service users who do not meet the criteria for MAPPA level 2 and 3 but are assessed as posing a risk of serious harm to the public. Identification as a MARE case is based on the judgement of the clinical team that the service user represents a high risk of serious harm to others, and that this risk is current.

6.88 Consideration for a MARE referral should have been made when he was admitted to Yewdale ward in March 2018. When CMHART attended his flat to complete the MHA assessment prior to his voluntary admission Mr M was talking about people breaking into his flat and he had a knife on the table (and one in the bedroom).

6.89 On 25 September 2018, the police completed a vulnerable adult referral for Mr M because he had attended the police station and reported that someone was coming to get him. He was not seen by the team until 30 October 2018 when he was visited by CCO1 and CCO2. During the visit Mr M was anxious and agitated, and there was a knife visible in the room.

6.90 On 30 October 2018 Mr M was showing evidence of increasing risk with the presence of the knife in the room. There had been recent contact with the police and Mr M had a history of non-compliance with treatment and services which could lead to him becoming increasingly dangerous.

6.91 We were provided with five risk documents printed from GRiST for 2018 (January, March, April, September, and November 2018). In January, his risk of harm to others and property (these two risks are considered a single risk in GRiST) was rated as low. In March this changed to medium, but there was no explanation for the increase in risk within the section on harm to others and property. In fact, the written entries were identical to the January version.

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[87] *Mental Health Decision Support for Everyone.* https://www.egrist.org/

[88] *National Confidential Inquiry into Suicide and Safety in Mental Health.* https://sites.manchester.ac.uk/ncish/

6.92 The next revision was dated 12 April 2018, presumably revised while he was an inpatient, but the content was again identical to the previous version, except that there was a modified safety plan to take account of his inpatient status and, his risk of harm to others and property had reverted to low, with no explanation for the change. All of the written entries within the detailed risk domain sections were dated from the March revision and identical with it.

6.93 The next revision was in September, but again, all of the written entries were dated in April or March. There is reference at the beginning to the fact he had refused his depot on 14 September 2018, his aggression had increased, he was using alcohol and cannabis and there had been reports of an increase in Mr M's paranoia. The risk of harm to others and property remained scored as medium.

6.94 The Management Plan for this risk stated:

'2018-04-12: [Mr M] has been discharged from Yewdale ward this afternoon with continued support from the CMHT. They will monitor for any changes in this area. [Mr M] is able to notify services if he feels his needs change and has supportive parents'.

6.95 There is no plan stated for the concerns described above.

6.96 Generally, in all five versions of the GRiST, there is very little reference to Mr M's past history of violence, there is no mention of the fact that he had been detained under Section 37/41 MHA on two separate occasions in 1996 and 2008. Where there was reference to his offence of armed robbery in 1995, it was (incorrectly) stated that he served a prison sentence for this. There is a reference to the assault against his brother's friend in 2007, but there is no record that he was convicted of inflicting grievous bodily harm with intent and it was stated that a Section 37 was recommended, from which he was discharged.

6.97 Issues identified with GRiST raised during interviews with staff were:

6.98 **Training** - despite assurance from senior management that training in GRiST had been provided, clinicians consistently told us that they had not received any specific training in its use. We were told that practitioners often relied on their colleagues to show them how to use the system.

6.99 **Use/practice** - a senior clinician told us that in their view, it was a very poor tool and very complex. It took staff a long time to complete (often at least an hour). Apparently, doctors were told that they did not have to complete it because it was not felt to be worth their while to spend time on it when there was such a shortage of medical staff. Instead they wrote a narrative risk assessment in their clinical letters to the GP. Even when others had completed the GRiST, senior medical staff did not find the output from it useful in risk management. This was in part because of its complexity and also because when it was updated, important historical risk information would be lost, as it was not carried over to the new version.

6.100 **Fitness for purpose** - a previous DHR[89] from 2015 found that in that particular case, 'Reliance on the GRiST tool to determine risk… proved to be inadequate and inaccurate'. Staff interviewed in this case appeared to agree with that conclusion, citing the problems in completing the tool, the time taken to do so and the fact that important historical information was not included, even though it was contained in other documents within the clinical record. Apparently, consultants had consistently expressed their reservations over its value as a risk tool.

6.101 **Response to previous DHR (2015)** - as noted above, a previous DHR had expressed concerns over the use of GRiST as the risk tool for CPFT. In their report they recommended:

'The GRiST tool continues to be used in Cumbria and it is strongly recommended that CPFT consider an independent review that is outside the trust to review all risk assessment tools and the policies and procedures that support the use and delivery of such tools'.

6.102 We were told that such a review had not been completed in response to this recommendation.

6.103 **Future plans for risk assessment** - we have been informed (in 2020) that CNTW intend to discontinue using GRiST. Ultimately, they plan to move to a 'narrative based risk tool'. In a document dated 3 May 2020, they state:

'The new risk tool which requires development from initial ideas of concept through to operational delivery will form part of a comprehensive holistic clinical assessment package which was succinct and easy to use with 3 component parts.

- A checklist.
- A narrative.
- A formulation and risk management plan'.

6.104 In the subsequent plan, they state that this will take 24 months to complete. In the meantime, to have a risk tool which will be available within RiO,[90] North Cumbria mental health services will switch from GRiST to FACE,[91] until the new risk tool is completed.

6.105 In the Royal College of Psychiatrists report 'Rethinking risk to others in mental health services' (CR201)[92] from 2017, its summary of best practice stated:

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[89] *Domestic Homicide Review West Cumbria Community Safety Partnership.* https://www.copeland.gov.uk/sites/default/files/attachments/dhr_overview_final_2015.pdf

[90] *RiO is the electronic clinical record system.* https://www.servelec.co.uk/product-range/rio-epr-system/

[91] *Functional Analysis of Care Environments: FACE Risk Assessment & Management Recording Tools.* https://imosphere.co.uk/solutions/face-assessments/toolsets-risk

[92] *Rethinking risk to others in mental health services. RCPsych CR201, May 2017.* https://www.rcpsych.ac.uk/docs/default- source/improving-care/better-mh-policy/college-reports/college-report-cr201.pdf?sfvrsn=2b83d227_2

'…the primary process of risk assessment for psychiatrists: a structured history, mental state examination and clinical formulation, including risk formulation. Risk assessment should maximise the involvement of patients and carers, emphasising strengths, positive risk-taking and recovery'.

6.106 The use of GRiST, which is only used in a few NHS mental health services, does not appear to have supported the staff in CPFT in their risk management of Mr M. This is because of the time taken to complete the tool and the lack of a concise risk summary as an output from the tool. Even when there was reference to previous violent offending, these lacked details and were also inaccurate.

6.107 Decisions were made to change the level of risk to others and property during 2018 without any corresponding narrative which explained the reason for the changes, or any change in the risk management plan as a result.

6.108 Despite CPFT being warned of concerns about the use of GRiST, by its own senior clinical staff and in a recent DHR report, there does not appear to have been any plan to change the risk assessment tool, until the recent merger with CNTW. As the Royal College of Psychiatrists report makes clear, there is not an effective risk management tool available to secondary care mental health services at present.

6.109 However, providing an accurate and concise risk summary which contains all the relevant risk information and was readily available within the patient's clinical record, would be of considerable help to clinical staff in their day to day risk assessments of patients. In addition, reflective practice within clinical teams, that focussed on the risk management plans of their patients would greatly improve this area of their practice.

6.110 The NCISH report: 'The assessment of clinical risk in mental health services (2018)', includes the following in their clinical messages:

'Risk is not a number, and risk assessment is not a checklist. Tools, if they are used (for example as a prompt or a measure of change), need to be simple, accessible, and should be considered part of a wider assessment process. Treatment decisions should not be determined by a score.

Risk assessment processes are an intrinsic part of mental health care but need to be consistent across mental health services. Staff should be trained in how to assess, formulate, and manage risk. On-going supervision should be available to support consistency of approach. There is little place for locally developed tools'.

6.111 We support these views and believe they should be considered when the Trust implements its proposed risk assessment processes. They need to ensure that the issues identified with GRiST are not replicated with the interim solution of FACE or in the ultimate planned new risk tool.

6.112 It appears that the proposed new 'narrative' risk tool will include a checklist, which would seem to be at odds with the recommendation from the Royal

College which is quoted above.

Finding 10 - Trust risk assessment

Mr M's risk assessments were not updated as expected by policy and did not reflect his current risks.

Despite CPFT being warned of concerns about the use of GRiST by its own senior clinical staff and in a recent DHR report, there does not appear to have been any plan to change the risk assessment tool, until the recent merger with CNTW. Action to address this is now in progress.

Recommendation 13

The Trust must ensure that changes to their risk assessment tools are informed by current research and recommendations from independent bodies. Any newly developed tools should be based on current knowledge and informed by independent experts in risk assessment in mental health services.

They should also be subject to independent evaluation by experts in risk assessment before they are implemented.

Recommendation 14

The Trust must ensure systems are in place to maintain expected standards in clinical risk assessment and planning.

Medical reviews

6.113 Mr M did not have any planned psychiatric medical reviews in the 18 months prior to the homicide.

6.114 The appointments in November 2017 and March 2018 were made because of concerns about Mr M, in November 2017 because he disclosed that he had stopped taking his medication and in March 2018 because of concerns raised by his parents. On both occasions the response to concerns was met with prompt medical reviews.

6.115 However, later in 2018 CMHART was not responsive when Mr M required medical review. Mr M requested a medical review on 31 August 2018 because he was reluctant to accept the prescribed depot. This was the last time he accepted a depot.

6.116 He was placed on the waiting list for a medical review on 7 September 2018 and identified as a low priority. This was updated by CCO2 on 17 December 2018 when it was identified that Mr M was at risk of relapse and was requesting a medication review. This was reviewed on 10 January 2019 and Mr M was again identified as a low priority for a medical review.

6.117 Mr M 's father attended the CMHART base on 15 January 2019 because he had arrived at his parents' home in the middle of the night and they were concerned about his mental health and safety. His father was asking for an

urgent review. The CMHART duty worker sought advice from the CMHART doctor. The duty worker told us at interview that they would have been prepared to provide medication to Mr M as requested by his father.

6.118 The CMHART doctor did not agree to Mr M being given a depot because he had not received one since 31 August 2018 and had not had a medical review since his discharge from Yewdale ward. The advice from the CMHART doctor was for the care coordinator to complete a review of Mr M and then to book a medical review based on this assessment. The reasoning for this decision was not however recorded in the clinical notes. The subsequent assessment completed by CCO2 on 17 January 2019 resulted in Mr M being offered a medical review appointment for 24 January 2019.

6.119 We have concluded that based on Mr M 's risk history and the fact that he had not had any medication for more than three months he should have been a priority for an urgent medical review in the autumn of 2018. We are confident based on their previous reaction to requests for a medical review for Mr M (November 2017 and March 2018) that had the CMHART Consultant Psychiatrist been in post when the original request for a medical review was made in September 2018, they would have prioritised Mr M for an appointment. We believe that when his father attended the CMHART base in January 2019, the Consultant's response to the request for medication and a medical review would have been different because they had a good understanding of Mr M 's history and risk.

6.120 In 2018 and 2019 the Trust experienced considerable pressures in recruiting and retaining medical staff. In August, September, and October 2018 the CMHART Consultant Psychiatrist was the Responsible Clinician for two CMHART teams, the crisis team and Yewdale ward. The team told us they had access to three hours a week of consultant psychiatrist time, in addition to two days support from a Speciality grade doctor. The Trust has informed us that the consultant time was seven hours a week, and Speciality grade doctor time was three days a week. We have no explanation for this disparity. There is evidence however that due to the pressure on medical staffing due to substantive vacancies and lack of locums throughout the county there were weekly medical staffing meetings with Clinical Directors, operational mangers and HR representatives.

6.121 This resulted in CMHART being unable to provide routine appointments. Also, there was a waiting list for medical reviews and there was limited ability to provide urgent appointments. We were told at interview that medical staff were discouraged by Trust management from making routine appointments to see patients.

6.122 We were informed by the Trust that in line with 'New Ways of Working' it is not recommended that consultants routinely review all patients and that this function should be provided by their senior supervisory role within the MDT. However, in our view this supervisory function would not be possible with the minimal consultant time available. Staff in Allerdale told us that it was exactly this kind of supervisory function and access to consultant time that they

missed.

6.123 Staff were aware that the on call medical rota and crisis services were available to them but told us that what they needed was ongoing consultant support.

6.124 The Standard Operating Policy (SOP) for the Management of Waiting Lists in CMHART (October 2016) acknowledged that there were capacity issues that resulted in long waiting lists.

6.125 The SOP was intended to identify good practice with regard to managing waiting lists, and states that waiting lists should be discussed at CMHART leadership level, to formulate an approach for managing pressure and/or escalate to network level.

6.126 It further states that where a service user requires a review with a medical or non-medical prescriber for a specific intervention around prescribing or medication, they should be seen in the CMHART assessment clinic; and only if the assessment coordinator or care coordinator have determined that medical or nurse practitioner input is required.

6.127 This SOP does not appear to have made positive change.

Finding 11 - Medical reviews

The system for allocation of medical reviews was reactive and not fit for purpose, and waiting lists were lengthy and unmanaged. This resulted in a lack of medical oversight of Mr M's care for 18 months.

CMHART had limited access to medical support and the waiting list for medical reviews was not managed in line with the SOP.

Recommendation 15
The Trust must ensure that there are standards in place for the medical review of patients in Allerdale CMHART, and systems to ensure that standards are maintained.

Recommendation 16
The Trust must ensure that all service users who are prescribed an anti-psychotic have access to an annual medical review, either with a doctor or a non-medical prescriber.

CMHART Management

6.128 The community mental health teams in Cumbria (CMHART) are managed by a 'triumvirate' of an Operational Manager, a Clinical Lead for Psychosis, and a Clinical Lead for Non-Psychosis.

6.129 It was described to us at interview that the Non-Psychosis pathway would primarily be people with anxiety, depression, possibly bipolar without having psychotic symptoms, or personality disorder and post-traumatic stress disorders.

6.130 On the Psychosis pathway patients would have had a psychotic episode at some point in their life. They might have moved from Early Intervention Services or might have bipolar disorder with psychotic features in that pathway.

6.131 The Psychosis pathway should offer family interventions, education, education advice, and work around hearing voices and hallucinations. Treatment for the Non-Psychosis pathway should be cognitive behavioural therapy, structured clinical management process, and possibly one-to-one psychotherapy. After treatment patients would be discharged back to the care of their GP. The Non-Psychosis pathway was described to us as lasting roughly about 15 months but could be longer depending on individuals. There were staffing pressures within the CMHART management triumvirate. Whilst the Operational Manager was in post for the whole of 2018, there were periods of time when there was no Psychosis lead. Ultimately in December 2018 there was only the Operational Manager supporting the team. The Psychosis lead had stepped down and they were in the process of appointing a replacement. The Non-Psychosis lead was absent from work as a result of stress. The Operational Manager was new in post and inexperienced in management role and told us that supervision was variable in frequency and quality.

6.132 The internal investigation report states that ‘Leadership in the Allerdale CMHART during 2018 had been weak in addressing what had become dysfunctional team working and an embedded, traditional culture within the team that was resistive to change’. This is regarded as an incidental finding and it is stated that ‘this did impact on overall service delivery, although it is difficult to measure the specific impact on the Care Pathway of the patient. Concerns regarding Allerdale CMHART had been identified by the Senior Management Team and action had been initiated to enable service improvement, although it would be premature to provide any assurance on the impact of this management action’.

6.133 In December 2018, the CMHART was not meeting the key performance indicator for the completion of CPA, with less than 76% of patients under the care of the team having had a CPA review within the previous 12 months.

6.134 It is clear from correspondence and our interviews that the CMHART Operational and Network Managers were aware of the issues regarding the lack of timely CPA reviews. A Network Manager who joined the team in October 2018 identified a need to develop a plan to bring the CPA reviews in-line with policy. As a part of this process, a review of caseloads in November 2018 identified that CCO2 had a caseload of 46, 21 of whom were on CPA. The majority of these were overdue for CPA reviews, and some had not been completed for two years.

6.135 There are several team relationships that have been described to the investigation as ‘difficult’ and we have been told that morale within the Allerdale CMHART was at an ‘all time low’ in 2018. There were significant

difficulties recruiting nursing and medical staff. Medical staffing was described to us as being ‘on its knees’ and that patients could be waiting more than a year for a medical appointment.

6.136 This can be seen in the sickness figures and the types of incidents reported by the team. In June 2018, the Psychosis Lead twice reported staffing levels as an issue through the incident reporting system and identifying absence due to stress as an issue. In July 2018 it is reported that the team was operating with only 50% of the team in work.

6.137 Whilst in October 2018 another member of staff expressed concerns about the management of the waiting list, citing concerns about significant unknown risk and ‘inflated psychosis caseloads. Two members of the CMHART team approached the Network Manager in October 2018 with concerns about the lack of professional supervision and the size of their caseloads.

6.138 CMHART was managed by three Band 7s. The Operational Manager was accountable for key performance indicators, human resource issues (sickness and disciplinary) and day to day management of the team. Whilst the Psychosis and Non-Psychosis Leads were responsible for clinical supervision, the management of waiting lists and allocation of cases on their pathway.

6.139 This separation of responsibility and accountability resulted in tensions between the three of them, with the Operational Manager being accountable for performance but having little influence over clinical decisions. In addition, there was a lack of stability about the Psychosis Clinical Lead. Between January and April 2018, they were absent from work. When they returned to work, they wanted to step down from the post but continued on a part-time basis until October 2018. From November 2018 to January 2018 the post was not covered. Furthermore, the Non-Psychosis lead was absent from work due to stress in December 2018.

6.140 The internal investigation stated that they did not find that individual caseloads were excessive, but there were 108 patients waiting to be allocated, which represents a high level of need not being met.

6.141 It became evident from our interviews and documents reviewed that there were several indicators available to senior management that indicated performance issues in Allerdale CMHART:

- Long waiting lists for allocation to care coordinators.
- GRiST risk assessments not updated.
- Supervision and mandatory training not carried out.
- Incident reports expressing concern about high caseloads.
- High sickness absence, with work related stress cited.
- Turnover of senior staff.

6.142 In addition to this, very senior managers were approached directly by senior staff within the Trust to express serious concerns about the performance of the Allerdale CMHART.

6.143 We have been provided with documents that show there was a recognition that significant management and performance issues existed in Allerdale CMHART.

6.144 These appear to have been recognised by CNTW as part of preparation for the new Trust, which came into being in October 2019.

6.145 Actions taken to address these include;

- A professional standards investigation.
- Medical staffing review.
- Leadership workshops for senior staff across North Cumbria services.
- Detailed action plan in response to the internal investigation.

6.146 It is apparent that the new Trust has taken steps to address the quality issues raised. Because of the changes in structures, personnel and policy, it has not been possible to investigate what actions were taken when issues were raised with management prior to the Trust provider changes.

6.147 Further development took place in February 2020, which included Stress Risk assessment questionnaires, 1:1 interviews and a half day team development session. The Trust informed us that this work was very positively received, however, needed to be temporarily paused due to Covid-19. This is now being picked back up as part of an ongoing programme of development and cultural change within the team/service.

6.148 The family asked us to comment on the oversight of the quality of care which is the responsibility of NHS North Cumbria CCG. The CCG have told us that there were a variety of structures in place, including quality contract meetings, reviews of incidents, attendance at internal quality meetings, shared intelligence and reporting from regional NHSE colleagues via the quality surveillance group and with CQC regulators.

6.149 The CCG approach to review and assurance included:

- the incident review group (review of actions plans etc),
- attendance at internal quality meetings re surveillance/oversight,
- feed into formal quality contract meetings (QRGs) where further assurance may be required,
- CCG Quality reporting to the CCG and Governing Body, which may trigger an ‘assurance visit’ from CCG Quality leads,
- independent investigations may also be commissioned in some circumstances and;

- a reporting mechanism from the CCG to the regional arrangements to the NHSE Quality Surveillance Group where the link is made with CQC and other commissioners and regulators.

6.150 As part of this discussion NHS North Cumbria CCG also referenced the CQC report in September 2019 which highlighted that there had been *'little improvement in Cumbria Partnership NHS Foundation Trust'*. From this and their internal quality monitoring the CCG developed a case for change which included commissioning CNTW to improve the overall delivery of mental health services in North Cumbria.

Finding 12 - CMHART Management

Serious concerns had been raised internally about the provision of a quality service by Allerdale CMHART.

We have been made aware of high caseloads, high sickness and turnover of senior staff, inadequate supervision, lack of CPA reviews, missed depots, lack of medical staff leading to long waits for medical reviews, and incident reports of a range of concerning HR issues.

Recommendation 17
The Trust and CCG must provide assurance that the quality and management concerns in Allerdale CMHART have been addressed.

7. Serious incident review

7.1 The terms of reference require us to review the following areas in relation to the Trust internal investigation:

"Review the Trust post incident internal investigations and assess the adequacy of their findings, recommendations, and action plans.

Review the progress that the Trust has made in implementing the action plan associated with their internal investigation."

7.2 The Trust internal report has been reviewed using our structured approach, which is detailed at Appendix C. We have developed a robust framework for assessing the quality of investigations based on international best practice. We grade our findings based on a set of comprehensive standards developed from guidance from the National Patient Safety Agency, NHS England Serious Incident Framework (SiF) and the National Quality Board Guidance on Learning from Deaths.[93] We also reviewed the Trust's policy for completing serious incident investigations to understand the local guidance to which investigators would refer.

7.3 In developing our framework we took into consideration the latest guidance issued by the American National Patient Safety Forum/Institute of Healthcare Improvement RCA[2] (or Root Cause Analysis and Action, hence 'RCA Squared') which discusses how to get the best out of root cause analysis investigations and suggests that there are ways to tell if the RCA process is ineffective. We have built these into our assessment process.

7.4 The warning signs of an ineffective RCA investigation include:

- There are no contributing factors identified, or the contributing factors lack supporting data or information.
- One or more individuals are identified as causing the event; causal factors point to human error or blame.
- No stronger or intermediate strength actions are identified.
- Causal statements do not comply with the 'Five Rules of Causation'.[94]
- No corrective actions are identified, or the corrective actions do not appear to address the system vulnerabilities identified by the contributing factors.
- Action follow-up is assigned to a group or committee and not to an individual.

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[93] *National Quality Board: National Guidance on Learning from Deaths.* *https://www.england.nhs.uk/wp- content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf*

[94] *Marx, D. Patient safety and the "just culture": a primer for health care executives. New York: Columbia University Press, 2001.*

- Actions do not have completion dates or meaningful process and outcome measures.
- The event review took longer than 45 days to complete.

7.5 Our detailed review of the internal report is at Appendix C. In summary we have assessed the 25 standards as follows:

- Standards met: 13.
- Standards partially met: 5.
- Standards not met: 7.

7.6 We discuss our analysis below.

Analysis of Trust internal investigation

7.7 The Trust received communication from Cumbria Constabulary that the internal investigation could proceed, and it was formally started on 31 January 2019. Starting the investigation in a timely way is good practice, and in keeping with the expectations of the NHS SiF.

7.8 The Trust Incident and Serious Incidents that Require Investigation (SIRI) Policy[95] describes three levels of investigation: concise, comprehensive, and independent. It was noted that the internal investigation was commissioned as a 'Level 2 comprehensive investigation'. This is explained as:

'Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable. The investigation should be completed, and final report submitted to the CCG, within 60 working days of the incident being reported'.

7.9 This was the appropriate level of investigation, however in reality the investigation was commissioned to be completed by an independent associate as the investigating officer (IO), with support from a Clinical Advisor employed by the Trust. The investigating officer (IO) is an experienced senior nurse who has many years' training and experience in carrying out serious incident investigations.

7.10 The Clinical Advisor is a Consultant Psychiatrist working in the community in a different part of Cumbria. This was explained as providing relevant clinical expertise with a degree of independence from the Allerdale team, which is good practice.

7.11 Whilst very comprehensive, in our view the authors have produced a report which has attempted to provide the breadth and depth of an independent report, when the Policy requirement was for a Level 2 report. The outcome of this is a lengthy report which took from January to October 2019 to produce.

7.12 The report is 150 pages long and contains 80 pages of narrative chronology,

[95] *CPFT Incident and Serious Incidents that Require Investigation (SIRI) Policy, POL/002/006/001, May 2018.*

with commentary on events dating back to 1994. While attempting to gain the perspective of history is generally laudable, we question the relevance of this level of detail and comment in relation to more current events.

7.13 There is no explanation for the time delay in the report, and no clarification provided about whether permission for an extension was sought from NHS North Cumbria CCG. The Trust since provided a timeline of the investigation, which was planned to start in January 2019 and be completed in May 2019. The draft report was received on the 11 July 2019.

7.14 Still outstanding at that point was the review of the draft report with the family as agreed, which happened on the 9 August 2019. The report then proceeded through the Trust governance process and was provided to NHS England in October 2019.

7.15 NHS England (London Region) Independent Investigations Team issued guidance in April 2019 on engaging with families after a mental health homicide.[96] This provides clear best practice guidance to mental health provider organisations and states that 'families of victims and alleged perpetrators should be treated as key stakeholders and are an integral part of any review or investigation'.

7.16 There was an acknowledgement that there was confusion as to what had been initially agreed regarding family contact after the homicide, and this confusion caused distress to the family. The involvement of the family in the internal investigation was managed positively. The family told us that they did feel involved and listened to during the process and had opportunities to discuss the investigation with the IO. They have had sight of the final report and had the opportunity to have feedback and received an apology from the Executive Director of Nursing. The Trust did however undertake to keep the family updated on the progress of the action plan, which has not been done, despite requests made by the family for updates.

7.17 The family were less concerned about the time the report took to produce and were satisfied that the issues had been investigated so that they knew 'what' had occurred. However, they still had questions about responsibility and accountability that they wished this independent investigation to explore.

Adequacy of findings and recommendations

7.18 There were 36 findings made in total. The IO explained that each finding has a determination letter as to whether the finding is considered an incidental finding[97] (letter I), a root cause[98] (letter R), or is a statement of fact (letter F) in relation to the incident. There is no explanation of how these determinants were reached, and we believe there are potential linkages between issues that are not explored.

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[96] *Mental Health-Related Homicide Information for Mental Health Providers April 2019.* https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/08/Information-for-Mental-Health-Providers_V4.0.pdf

[97] *IO explanation: An incidental finding is a gap in care but one which did not contribute to the outcome*

[98] *IO explanation: A root cause is an underlying or initiating cause of a causal chain which led to the outcome.*

7.19 To illustrate this, we have used the example of the analysis and findings about risk assessment.

7.20 The table below shows that it is considered a fact (F) that there is an appropriate clinical risk assessment policy and framework. We agree there is a policy but question the appropriateness of the policy in relation to the Trust use of the GRiST risk assessment tool (discussed in the risk assessment section above).

7.21 There are a further five findings about risk assessment and risk management, four of which are regarded as incidental (I) and one as a root cause (R).

Finding number	Description	Category
16	Clinical Risk Policy	F
17	Risk assessment prior to the incident	I
18	Narrative risk assessment leading up to the incident	I
19	Risk Management Plan	R
20	Multi Agency Risk Evaluation (MARE)	I
22	Clinical Risk Training	I

7.22 In findings 17 and 18 the IO notes that the GRiST had not been updated since April 2018, and there was limited risk information in the clinical notes, with no effort to engage Mr M. The recording and plans were described as 'weak'. We agree with these two findings but question their formulation as 'a gap in care but one which did not contribute to the outcome'. We believe the lack of up to date and accurate risk assessments definitely contributed to the outcome.

7.23 Findings 20 and 22 are also regarded as 'incidental' and refer to the fact that the clinical team did not use the MARE process, and that there was no evidence of mandatory training in risk assessment and management.

7.24 It is stated in Finding 19 that the risk management plan fell below the expected policy standards, and that this was regarded as a root cause (R).

7.25 In our view the weak risk management plan should be regarded as a care delivery problem,[99] and the other issues as contributory factors.[100]

7.26 A root cause can be defined as:

'The most significant contributory factor, one that had the most impact on system failure and one that if resolved would minimise the likelihood of a re-

[99] *Care Delivery Problems are problems that arise in the process of care, usually actions or omissions by staff e.g. care deviated beyond safe limits of practice, failure to monitor, observe, act.* https://webarchive.nationalarchives.gov.uk/20171030124143/http://www.nrls.npsa.nhs.uk/resources/

[100] *A key stage of Root Cause Analysis involves identifying those issues (contributory factors) which may have had an influence or may have directly caused a patient safety incident.* https://webarchive.nationalarchives.gov.uk/20171030124143/http://www.nrls.npsa.nhs.uk/resources/

occurrence.'[101]

7.27 Applying this definition to the analysis of the risk assessment issues which are identified above; the weak risk management plan we believe should be seen as the result of the other contributory factors, and not as the underlying cause of the systems failures that contributed to the homicide.

7.28 The associated recommendation (Recommendation 4) suggests that the policy and training be aligned to the new Trust policy, with a mandatory training requirement, and a targeted approach to training for Allerdale CMHART. It is further recommended that the impact of this training be measured, and that there is assurance that safeguarding, and MARE referrals are made appropriately. We agree with the intention of this recommendation, which appears to address the contributory factors of a lack of training and quality assurance. It is silent however on the topic of the use of GRiST.

7.29 There are six findings which are regarded as 'root cause':

Finding number	Description	Category
4	Care Coordination governance	R
6	Monitoring	R
7	Disengagement	R
9	Diagnosis	R
11	Zuclopenthixol Administration	R
19	Risk Management Plan	R

7.30 If these are all regarded as root causes, it would be expected that they would map onto the recommendations, to address fundamental systems issues. There are 10 recommendations in total, listed below:

Number	Recommendation
1	Allerdale CMHART
2	CPA/Care Coordination
3	Parents Needs
4	Assessment and Management of Risk
5	Engagement, monitoring & supervision
6	Allerdale CMHART Capacity
7	Discharge from Yewdale to CMHART
8	Inter-Agency Communication
9	Physical Health Care
10	Duty of Candour

[101] *Root cause analysis - using five whys.* http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

7.31 The recommendations are provided in a list at the end of the report, rather than as they arise in relation to findings. This makes it difficult to see how they have been synthesised from the analysis and findings that are within the body of the report.

7.32 The recommendations do not easily map onto findings, and do not appear to relate directly to the findings which are identified as root causes. Themes are not presented in any order or level of priority.

Action plan progress

"Review the progress that the Trust has made in implementing the action plan associated with their internal investigation."

7.33 We were provided with information about implementation of the action plan in August 2020. We have reviewed the information provided and discussed the implementation below. Our detailed analysis is at appendix G.

7.34 There were 10 recommendations made, listed below;

Number	Summary
1	Allerdale CMHART
2	CPA/Care Coordination
3	Parents Needs
4	Assessment and Management of Risk
5	Engagement, monitoring & supervision
6	Allerdale CMHART Capacity
7	Discharge from Yewdale to CMHART
8	Inter-Agency Communication
9	Physical Health Care
10	Duty of Candour

7.35 We have assessed the information provided by the Trust using our Niche Investigation Assurance Framework (NIAF). Assurance questions are based around the key areas of completeness, embeddedness, and impact.

Score	Assessment category
0	Insufficient evidence to support action progress / action incomplete / not yet commenced
1	Action commenced
2	Action significantly progressed
3	Action completed but not yet tested
4	Action complete, tested and embedded

5	Can demonstrate a sustained improvement

7.36 The evidence is 'scored' using these categories:

7.37 We have carefully reviewed the information that the Trust has provided as evidence of implementation for each of the 10 recommendations, and results are as below:

Recommendation	NIAF grade
Recommendation 1	2
Recommendation 2	3
Recommendation 3	2
Recommendation 4	2
Recommendation 5	2
Recommendation 6	2
Recommendation 7	2
Recommendation 8	1
Recommendation 9	1
Recommendation 10	4

7.38 In summary it is clear that the Trust has taken a structured approach to the implementation of the action plan and is able to evidence that some action has been taken, but not completed. There is less evidence of the embeddedness and impact of these actions on making lasting practice changes.

7.39 The approach to the family has been of a high standard, and we have had feedback that the family appreciated the time and care taken. The Trust sent a formal letter of apology to the family and undertook to keep in touch about actions taken. However, the family have told us that they have not been kept up to date about progress of the action plan.

Finding 13 - Serious incident review

The internal report was lengthy, overly detailed and went well beyond the expected policy timescales.

Family engagement by the lead investigator throughout the initial investigation process was initially very positive, but the Trust has not followed through on the promise to keep in touch about progress.

There is evidence that there are actions in progress to address the recommendations.

Recommendation 18
The Trust and CCG must ensure that serious incident investigations are carried out at the appropriate levels and within expected timescales.

Recommendation 19
The Trust must provide evidence of assurance of the serious incident investigation action plan implementation, that is then shared with Commissioners.

8. Domestic Homicide Review specific terms of reference

8.1 This section of the report provides analysis of the issues within the wider system including health care. The focus of this section of the report is on the following overarching section of the terms of reference:

"Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims".

Specific terms of reference

8.2 To structure our analysis, we have discussed the issues under the following headings:

- Interagency information sharing and communication.
- Domestic abuse.
- Domestic abuse local strategy.
- Matricide.

Interagency information sharing and communication

8.3 The agencies relevant to this section of the review are:

- Cumbria Constabulary.
- Cumbria Partnership NHS Foundation Trust (now CNTW).
- Cumbria County Council.
- NHS North Cumbria CCG.
- Two GP practices: Solway Health Services, Workington and Castlegate GP Surgery, Cockermouth.

8.4 We reference the material discussed in the agency sections above, using the detailed terms of reference below to guide our analysis:

"Identify any issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and perpetrator and to work effectively with other agencies?

Was information sharing within and between agencies appropriate, timely and effective?

Were there effective and appropriate arrangements in place for the escalation of concerns and how were these shared?

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

8.5 There are two clear routes within and between the above services that provide a framework for multi-agency communication, particularly about risk: these are the safeguarding structures and the MAPPA/MARE framework. We have commented on these, and on learning identified in previous reports.

Safeguarding/adults at risk

8.6 As discussed in the safeguarding section above we have concluded that there were no missed opportunities in relation to adult safeguarding. This relates to the expected statutory functions in relation to potential 'adults at risk'.

8.7 However, while Mr M did not meet the formal criteria of 'adult at risk', clearly the police were aware that Mr M was in need of support in March and September 2018, and that he was vulnerable, and at risk of harm to himself and or others. The police reported 'information only' concerns regarding Mr M 's mental health. As noted above, the police did not share the detail of what had occurred with mental health services, and this has been identified as a learning point. See recommendations 4, 5, 6 and 7.

MAPPA/MARE structures

8.8 The Multi-Agency Policy indicates that the identification of a MARE case is based on the judgement of the clinical/care team that the service user represents a high risk of serious harm to others, and the risk is current (that is, it is not a theoretical risk in the long term). Serious harm is defined as 'an event which is life threatening and/or traumatic, from which recovery, whether physical or psychological, can be expected to be difficult or impossible'.[102]

8.9 There are two missed opportunities to convene a MARE review: prior to discharge from Yewdale ward in April 2018 and in September 2018. The Policy advises clinical staff that when deciding to refer a service user into the MARE process the following points should be considered before making the referral:

- Evidence of increasing risk and/or patterns of behaviour (e.g.: the use or presence of weapons etc) and/or a known victim (named) as 'at risk'.
- Offending behaviour linked to dangerousness and/or increased contact with the Police (e.g.: threats, possession of weapons, assault, sexual offending etc).
- Regular reporting of dangerous incidents from the community.
- History of non-compliance with treatment/services and/or difficulty in engaging service users leading to increasing dangerousness.
- Child Protection issues.
- Hospital Orders (e.g.: Sections 37, 37/41, 47, 48, 45a Mental Health Act

[102] *MAPPA Guidance 2012 Version 4, Section 11.7.*
https://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance- 2012-part1.pdf

1983 (as amended 2007) moving into the local community.

- Restraining or injunction orders involving staff, other service users, partners, or Trust property.
- Adverse incidents involving dangerous behaviour.
- Ex high secure, regional secure and low secure service users new to services from prison with knowledge of index offence of dangerousness.

8.10 The criteria were clearly met, and the Policy expectation is that the clinical team should make the assessment and referral into the MARE process, and in this instance the referral should have come from CMHART. It should be acknowledged however that local police were also in possession of risk information and could have instigated and/or supported the MARE referral process.

8.11 We have referred earlier to management and capacity issues within the CMHART team which we believe have impacted on the provision of a quality service in this case. However, we note that the Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy was due for review in January 2020. We do not have any information about a revised Policy and suggest that learning identified in this review is included in this process.

Multiagency learning from previous reports

8.12 West Cumbria Community Safety Partnership (CSP) published a DHR review in 2015.[103] We reference this because there are recommendations made about several areas that have arisen in the course of this review:

- GP awareness and enquiry about possible domestic abuse.
- Mental Health Trust review of the risk assessment tool, policies, and procedures.
- Police officers should record any comments, made by a vulnerable adult that could be considered threatening to any third party or significant in any other way. These comments should be included in the Vulnerable Adult (VA) report.

8.13 We have not reviewed this action plan but have discussed oversight of the action plan with the relevant Cumbria County Council department. We were informed that this would be the responsibility of the relevant CSP. There is a joint protocol with the three CSPs (Allerdale, South Lakeland, North Cumbria), but no countywide coordination of oversight of actions.

8.14 In our view these issues remain directly relevant to our findings in this case.

8.15 We have been provided with an update by NHS North Cumbria CCG on action taken following the previous report. We were informed that Domestic

[103] *Domestic Homicide Review West Cumbria Community Safety Partnership.* https://www.copeland.gov.uk/sites/default/files/attachments/dhr_overview_final_2015.pdf

Abuse has been included in training for GPs. Victim Support delivered training at training sessions in 2019, attended by GP practice staff.

8.16 The CCG Safeguarding Team routinely circulates resources and Safeguarding briefings to primary care colleagues. A number of more targeted resources including advice and support in relation to Domestic Violence have been sent during Covid-19. GPs have also been signposted to the Royal College of GP's website.

8.17 Some GP practices have developed their own policies and the CCG is in discussion about the development of a standard process and Policy with primary care colleagues. The expectation is that a Practice would have access to a Domestic Abuse Policy. As above, the action is to produce a standard process and Policy.

8.18 In the interim there is a CCG Domestic Abuse and the Workplace Policy. Practices have also been signposted to advice on the RCGP website, and Safe Lives and MARAC materials have been circulated.

8.19 The CCG has recently agreed (in 2020) in principle with police and other agencies that weekly MARAC meetings will be held (they are currently monthly). The CCG will engage with the working group and the intention is to continue to engage General Practice and promote and facilitate the proportionate sharing of MARAC information sharing with GPs, if possible, via a systematised process.

8.20 Cumbria County Council recognises it should have a structure for oversight of actions for DHR's for the whole council. Currently the process for consideration of all investigative reports (SAR, DHR, SCR) is being considered. Specifically, for DHRs, the outcomes of DHR and any recommendation will be considered by the Council Internal Domestic Abuse Group with a recommendations report to be sent to the Directorate Management Team. This will also cascade to individual services teams with recommendations about practice and policy.

8.21 The County's Safer Cumbria Domestic Abuse Group (Multi agency) is in the process of developing a protocol which will include a structure for county wide oversight together with the Community Safety Partnerships.

Finding 14 - Interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. The local MAPPA/MARE policy is overdue for review.

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

North Cumbria CCG has carried out actions in relation to previous recommendations.

Recommendation 20

The Cumbria MAPPA/MARE partnership agencies: Cumbria Partnership NHS Foundation Trust/Cumbria Constabulary/Cumbria Probation Trust/Cumbria County Council Adult Social Care should carry out an update of the current policy, to include audit of whether the MARE process is being used appropriately and including lessons identified in this review.

Recommendation 21

Safer Cumbria and local Community Safety Partnerships should develop systems to ensure there is oversight of the implementation of action plans from Domestic Homicide Reviews.

Domestic abuse

8.22 This section explores any awareness of domestic abuse within the family, whether this was known to any agencies, and how it may have been acted upon. The family were concerned that there may be an unnecessary and inappropriate focus on the possibility of intimate partner violence. We have however taken a broader view, to encompass risk of harm to others within the family.

8.23 The detailed terms of reference are below:

"Explore whether the victim's family had any knowledge of domestic violence by the service user, if so, how was this knowledge acted upon?

Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies."

8.24 Both Mr M and Annie had made disclosures of family relationship difficulties to healthcare teams prior to the homicide, often in indirect ways. Both mentioned arguments, psychological difficulties such as depression, anxiety, and 'stress' in relation to problems at home.

8.25 In Annie's case, stress, anxiety, and depression related to her care of Mr M was disclosed to her GP and suggested indirectly to her employer's Occupational Health service. As discussed above there were missed opportunities to ask questions about potential risk of harm, and we have made recommendations accordingly.

8.26 Police and mental health services had information about potential risks to members of Mr M 's family in 2018, and awareness of historical harm caused.

- In March 2018 he had been carrying two or three knives for protection, which his mother had removed. He had however banged on his parents' door and they had returned the knives because they had '*not felt safe to refuse him'*. The family have since clarified that his parents did not feel unsafe, nevertheless the notes record this as a risk issue, which was not

acted upon.

- In March 2018 Mr M had recently had a physical altercation with his brother, he was drinking heavily and using illicit substances.
- In October 2018 knives were seen in his flat, and while contact was made with parents regarding concerns about him, there was no assessment of possible risk of harm to his parents.

8.27 There does not appear to have been any collateral information gathered about the family perspective or concerns about risk. We were told about longstanding animosity towards his brother, and of times that he has 'fallen out' with his parents and refused to see them, for no apparent reason.

8.28 The information that was conveyed to CMHART was not developed into a formulation of risk, with any attempt to understand its origins or focus.

8.29 There was no review of plans after his parents told CMHART staff that they were too afraid not to return his knives to him when he demanded them.

Finding 15 - Domestic abuse

In March 2018 there was no routine enquiry by police about the safety of Mr M 's parents, after it was reported that his parents had returned his knives because they had felt it was not safe to refuse.

The GP did not make routine enquiries about domestic abuse.

Cumbria County Council managers did not make routine enquiries about domestic abuse.

Trust staff made no enquiries about safety in relation to the family in March or October 2018.

Recommendation 22
NHS North Cumbria CCG must develop and implement policies to support routine enquiry by GPs about domestic abuse.

Recommendation 23
Cumbria County Council must develop and implement employment policies to support routine enquiry about domestic abuse.

Recommendation 24
The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members.

Recommendation 25
The Trust must ensure that where risk to family members is reported, risk assessment must be updated, and victim safety planning becomes part of the risk management plan.

Domestic abuse local strategy

8.30 We have accessed the Cumbria County Council Domestic Abuse strategy[104] and have been given information about how this has been operationalised. We were told that each partner organisation is responsible for the development of local protocols and the training of their staff. There is no central budget to support this.

8.31 We were informed that the 2018 Strategy was not translated into a formal action plan, and the current structures are undergoing changes. Within the strategy there is no mention of risk to parents from adult children.

Finding 16 - Domestic abuse local strategy

There is no implementation plan for the current Safer Cumbria domestic abuse strategy.

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

Recommendation 26
Safer Cumbria must develop and implement a comprehensive domestic abuse strategy which includes learning from this review.

Matricide

8.32 In this section we offer a perspective on the particular aspect of matricide, tragically illustrated in this homicide, in accordance with the terms of refence below:

"Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office."

8.33 Matricide is defined as the killing of a mother by their son/daughter and patricide the killing of a father by their son/daughter. Parricide is defined as the killing of a parent by a child of any age. This could include biological parents, stepparent or adoptive parents.

8.34 A review of parricide undertaken as part of the National Confidential Inquiry into Suicides and Homicides by People with Mental Illness identified two types of parricide offences, from their review of the literature. These are those offences committed by adolescents and those committed by adults. In the latter group, they found that the perpetrators were either mentally ill, particularly with psychosis or there were antisocial behaviour/violent personalities. They also noted that schizophrenia was the most common diagnosis.

[104] *Cumbria Domestic Abuse Strategy, 2018 – 2020.*

Parricide and mental disorder

8.35 The rates of mental disorder in parricide offenders varies according to the population studied. For example, in a Canadian study (Bourget et al 2007), only 8% of matricide perpetrators and 6% of patricide perpetrators were found not to have a mental disorder. In that sample, two-thirds of the male parricide offenders were motivated by delusional thinking. This reflects other studies, for example in a study from the USA, they identified four factors which were significant in the parricide offences. These were:

- Acute psychosis – 47%
- Impulsivity – 28%
- Alcohol and substance misuse – 24%
- Escape from enmeshment[105] – 15%

8.36 In another large study from a high secure hospital in England (Baxter et al, 2001),[106] they studied consecutive admissions over a 25 year period and identified 98 admissions over that period who had committed parricide offences, of whom six were double parricides. They compared this group with a group of patients who had killed strangers. They found that the group committing parricide offences had a higher proportion of patients with schizophrenia compared to the other group where the commonest diagnosis was of personality disorder.

8.37 They also found that the parricide group were less likely to have a criminal history, there was a higher incidence of previous attacks on the victim. One important factor that they noted was that they concluded that the parents may have placed themselves at risk by being more tolerant of violence and seeing it as an inevitable consequence of their son or daughter's schizophrenic illness.

8.38 In another study undertaken as part of the National Confidential Inquiry (Rodway et al 2009)[107] which was not specifically focussed on parricide, they studied the methods of homicide compared by diagnostic group. They found that just over half of all perpetrators with schizophrenia had killed a family member or current/former spouse. They found that the majority had active symptoms at the time of their offence, mostly delusions and/or hallucinations. And of these, over two-thirds reported experiencing delusions specifically related to their victim. They found that of all homicide offenders with severe mental illness, half also had a comorbid alcohol and/or drug dependence/misuse problem. They also found that these patients were more likely to use a sharp instrument in the homicide and therefore highlighted the importance of enquiring into the carrying of weapons by patients with

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[105] *Enmeshment is a psychological term that describes a blurring of boundaries between people, typically family members. Salvador Minuchin. (2005). Contemporary Authors Online. Retrieved from http://www.gale.cengage.com/InContext/bio.htm*

[106] *Baxter, H., Duggan, C., Larkin, E., Cordess, C., and Page, K. (2001) mentally disordered parricide and stranger killers admitted to high security care. The Journal of Forensic Psychiatry. 12, 287 – 299.*

[107] *Rodway, C., Flynn, S., Swinson, N., Roscoe, A., Hunt, I. M., Windfur, K., Kapur, N., Appleby, L., and Shaw, J. (2009) Methods of homicide in England and Wales: a comparison by diagnostic group. The Journal of Forensic Psychiatry & Psychology. 20, 286 – 305.*

schizophrenia.

8.39 A literature review of the relationship between schizophrenia and matricide (Schug 2011)[108]reviewed 61 publications, which included case reports, descriptive studies, and comparison studies. They found that offenders with schizophrenia were overrepresented and the prevalence of schizophrenia and other psychotic illnesses was significantly greater than in the general population. Also, the rates of schizophrenia were at the highest end of the range for all homicides (6% - 50%).

8.40 However, they concluded that matricide was not a specific schizophrenic crime and it was difficult to ascertain the motive for the offending in the studies that they reviewed. Even in perpetrators with schizophrenia, there was evidence of pathological family dynamics and increased violence which were present in other cases.

Matricide in England and Wales

8.41 In the first national analysis of parricide using the Home Office Homicide Index for England and Wales (Holt 2017),[109] all recorded cases of parricide over a complete 36-year period (January 1977-December 2012) were identified. There were 693 incidents of parricide recorded in England and Wales, suggesting a mean of approximately 19 incidents per year. There were 716 victims in total over this period. Despite the general downward trend in homicides that has been observed since 2002/03 across England and Wales, including domestic homicides, the rate of parricides has remained stable, at approximately 0.04 victims per 100,000 population per year. The study found that 35% of offenders were intoxicated at the time of the killing(s). For offenders, this is almost double the proportion found in all homicides in England and Wales.

8.42 The Homicide Index includes a category of an 'irrational act' for the killing(s). In the parricide cases with this category, it was more frequently used as the main circumstance with female victims (35%) compared with male victims (14%), this difference was statistically significant. Additionally, the use of diminished responsibility as a partial defence constituted 24% of homicide convictions in parricide cases, but only 5.5% of overall homicide conviction outcomes. Only 44% of parricide offenders were detained in prison (or its equivalent in the case of juveniles). This compares with the 94% of all homicide offenders that are detained in prison. Furthermore, while 62% of all homicide offenders received a sentence of life imprisonment, only 38% of parricide offenders received this sentence.

8.43 Hospital Orders were widely used in parricide cases, again much more so compared with homicide cases generally (31% vs. 6%). While the findings presented in this study does support the idea that mental illness plays an

[108] *Schug, R. (2011) Schizophrenia and Matricide: An Integrative Review. Journal of Contemporary Criminal Justice 27(2):204- 229.*

[109] *Holt, A. (2017). Parricide in England and Wales (1977–2012): An exploration of offenders, victims, incidents, and outcomes. Criminology & Criminal Justice.*

important role in the perpetration of parricide, the author was clear to point out that this study still suggests that most parricides are not the product of mental illness.

Implications for risk management

8.44 It could be argued from reviewing the literature on parricide and then comparing it with the broader work on homicide committed by mentally disordered offenders, that there may not be anything particularly different about those offenders who kill their parents compared to those who kill other family members. In fact, there have been a number of recent high-profile cases where a parent and sibling or other family member was killed at the same time. As parricide is so rare, it is probably not possible to distinguish this group from the rest of the mentally disordered offenders who kill a family member.

8.45 However, we wish to highlight three important factors:

- The importance of active symptoms of mental illness at the time of the offences. This is particularly true when these are delusions relating to family members. In turn, this then emphasises the importance of optimum clinical management of patients, particularly ensuring assertive treatment, including compliance with antipsychotic medication.
- Comorbidity of mental illness with alcohol and/or drug use. This has long been recognised as a very significant factor in increasing the risk of violence towards others in patients with schizophrenia.
- Effective liaison with the family, not only to obtain information related to risk but also to offer illness education for the family and highlighting the importance of compliance with medication for their family member. This was also highlighted by the National Confidential Inquiry who recommended that services should explore the relationship between family members and in particular, enquire about previous violence and delusional beliefs relating to family members.

8.46 Finally, at least one of these studies (Byoung-Hoon Ahn et al, 2012)[110] raise the issue of increasing risk of harm to parents who actively seek to promote treatment compliance in their children or who may be actively involved in their involuntary admission to hospital. This is particularly relevant to their role as the Nearest Relative under the Mental Health Act, where their consent is required for admission under Section 3.

[110] *Byoung-Hoon Ahn, Jeong-Hyun Kim, Sohee Oh, Sang Sub Choi, Sung Ho Ahn and Sun Bum Kim. (2012) Clinical features of parricide in patients with schizophrenia. Australian & New Zealand Journal of Psychiatry, 46, 621 – 629.*

Finding 17 - Matricide

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

Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

Recommendation 27
The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy, and procedures.

Recommendation 28
The Home Office should incorporate learning about matricide and parricide into domestic abuse prevention strategies.

9. Lessons identified/summary

9.1 As part of the terms of reference we are asked to identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from March 2018 to the incident occurring in January 2019.

9.2 In our analysis we have reviewed the conclusion of the internal investigation, which was that the homicide was predictable. The internal investigation concluded that 'the risk posed by the patient, in considering his history, always had the potential, if unmonitored and unchecked, to develop into an immediate and acute threat'.

9.3 We agree that there was a potential for harm to others, which has occurred historically when he has been mentally unwell and/or intoxicated. The last incident of serious harm was however in 2007. There is the report of him assaulting his brother in March 2018, with no use of weapons and no serious injury.

9.4 Mr M has also had relapses in his mental health when he has not presented as violent towards others, albeit engaging in risky behaviours such as threatening neighbours, carrying knives, and making threats of violence.

9.5 In March 2018 he agreed to be admitted to hospital and was cooperative with taking a revised medication regime. In October 2018 he asked for his medication to be reviewed, which was never completed. It was identified that he was at risk of relapse in December 2018, but a medication review was again not carried out.

9.6 In its document on risk to others, the Royal College of Psychiatrists Scoping Group[111] observed that: '*Risk management is a core function of all medical practitioners and some negative outcomes, including violence, can be avoided or reduced in frequency by sensible contingency planning. Risk, however, cannot be eliminated. Accurate prediction is challenging for individual patients. While it may be possible to reduce risk in some settings, the risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour*'.

9.7 We have not had access to the psychiatric reports prepared for Court afterwards, which may provide some insight into his mental state and motivation. It is reasonable to assume that Mr M was mentally unwell at the time, as he was known to be relapsing, and was subsequently detained under the Mental Health Act. We do not know however what the psychotic thinking may have been which precipitated the homicide.

[111] *CR201 (Royal College of Psychiatrists, 2017)* https://www.rcpsych.ac.uk/members/supporting-you/assessing-and-managing-risk-of-patients-causing-harm

9.8 If we regard the homicide as attributable to his mental state at the time, there are certainly gaps and omissions which we believe could have minimised the risk of an act of serious violence occurring.

9.9 After previous offences, Mr M has been the subject of two applications of Section 37/41 MHA. The intention of this section is to divert the offender from a custodial sentence to a hospital for treatment. There is no limit to the time a restricted hospital order is in force so that the period of detention will be determined by the need for treatment in hospital. There is clear guidance from the Ministry of Justice[112] regarding management of the risks involved in discharging individuals from these sections.

9.10 A recent study of reoffending[113] showed that patients discharged from medium secure care remain at long-term risk of being reconvicted after discharge, highlighting the need for long-term support. There is a recommendation that there be further analysis of reoffending patterns in patients who have been convicted of violent offences and detained in secure care.

9.11 The thematic diagram at Appendix H illustrates the contributory factors and root causes.

9.12 We have identified four primary root causes:

- Failure to adhere to the CPA Policy.
- Inadequate risk assessment.
- Inadequate treatment with medication.
- Inadequate system response to relapses.

9.13 The aggregate root cause we believe is the inadequate management oversight of the community team. As discussed earlier, we have identified a lack of senior management action and oversight of the inadequate functioning of the Allerdale Team.

Good practice

9.14 We have not identified any areas of best practice in the summary or care. The approach to the family after the homicide is however an example of good practice.

Findings and recommendations

9.15 We have listed below the findings that we have developed through our analysis of the care and service delivery issues. A thematic diagram of the

[112] *118 https://www.gov.uk/government/collections/working-with-restricted-patients*

[113] *119 A long-term follow-up study of patients discharged from a Medium Secure Unit: Preliminary reconviction rates after discharge Westhead, J., Clarke, M., Hatcher, R. & McCarthy, L. (2019). A long-term follow-up study of patients discharged from a Medium Secure Unit: Preliminary reconviction rates after discharge. Trent Study Day: Substance use and forensic mental health, 22 November 2019.*

issues is at Appendix H.

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

Finding 1 - GP/North Cumbria CCG/NWAS

While the GP surgery provided support and treatment in times of stress, there were missed opportunities to explore whether Annie required support as a carer or had any concerns about her own safety. No routine enquiries about domestic abuse were made, and no referral for a carer's assessment was made.

The GP practice did not have policies in place to support enquiries about domestic abuse or offer any risk assessment tools.

The approach of NWAS emergency teams was within expected practice.

Finding 2 - Cumbria Constabulary

Information about risk which had been logged by police was not conveyed to mental health services in sufficient detail.

There was no routine enquiry about the safety of Mr M 's parents after incidents in March 2018, when his mother had removed knives. The notes record that he had been given them back because his parents did not feel able to refuse, however the family state that this was not how they viewed it.

Risks concerns in the incidents of 19/20 September 2018 were not conveyed in appropriate detail.

Police did not activate the Multi-Agency Risk Evaluation (MARE) process in September 2018.

There was a lack of detail and continuity in the police approach to communicating with other agencies about Mr M , given their awareness of his mental health issues.

Finding 3 - Cumbria County Council and Unity

Cumbria County Council and Unity inputs were within expected policy and procedure.

Finding 4 - North Cumbria CCG/GP

The GP dealt with physical health issues, e.g. smoking cessation advice. Mental health concerns were dealt with completely by secondary care.

There was no communication between Mr M 's GP practice and his mother's GP practice, which is within normal expectations.

Mr M 's GP had very little communication from mental health services in 2018.

Finding 5 - Trust care and treatment

The CPA Policy was not followed with respect to care coordinator provision, care planning and reviews, and Trust systems did not identify or address these deviations from expected Policy within CMHART.

Assistant Practitioners were assigned to take on the role of care coordinators within the original Trust. We have not made a recommendation that this should stop, because the new Trust has confirmed that this is no longer accepted practice.

There was no care coordinator cover provided for a six-month period in 2018.

There is no evidence of an evidence-based treatment plan that was in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management.

Finding 6 - Trust medication management

The administration of depot medication was not recorded in the electronic clinical records.

Depot medication was missed, and there was no robust system for ensuring these were administered at the correct times or following up missed injections. This resulted in Mr M being unmedicated from August 2018 to January 2019.

Mr M was not stabilised on depot medication before discharge from Yewdale ward, West Cumberland Hospital.

Finding 7 - Trust inpatient management

Yewdale ward held the belief that Mr M's admission was as a result of his substance misuse and that once he had detoxified his mental health issues would resolve themselves.

Yewdale ward did not manage Mr M's admission in line with the Transfer and Discharge of Patients within and from Community Hospital/Step-up Step-Down Units, Mental Health and Learning Disability Services in Cumbria Partnership Foundation NHS Trust.

There was lack of continuity in care planning, admission, and discharge between Yewdale ward and CMHART. There was no liaison between the ward, CMHART or his family to plan and agree Mr M's discharge plan.

There was poor communication between the ward and CMHART following discharge.

Risk management on Yewdale ward did not take risk assessment into consideration, and leave was unplanned and unstructured, lacking curiosity about his social and family circumstances. This resulted in minimal time actually spent on the ward, which did not allow time for the treating team to get to know him or make contact with his family and assess the situation.

Yewdale ward had no admission and discharge Policy at the time.

Finding 8 - Trust family involvement

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

The family was not involved in care planning for Mr M, despite their requests to be involved and informed.

There were no carer's assessments requested or arranged for his parents, despite them specifically requesting this.

Risk management considerations were not applied to his family.

Finding 9 - Safeguarding

There is no evidence to suggest that Mr M or Annie should have been considered as an adult at risk in accordance with the Care Act 2014.

We conclude that there were no missed opportunities in relation to adult safeguarding. However we acknowledge that the family felt that Mr M was a risk to them, and described how they tried to manage this within the family.

Finding 10 - Trust risk assessment

Mr M 's risk assessments were not updated as expected by Policy and did not reflect current risks.

Despite CPFT being warned of concerns about the use of GRiST, by its own senior clinical staff, and in a recent DHR report, there does not appear to have been any plan to change the risk assessment tool, until the recent merger with CNTW. Action to address this is now in progress.

Finding 11 - Medical reviews

The system for allocation of medical reviews was reactive and not fit for purpose, and waiting lists were lengthy and unmanaged. This resulted in a lack of medical oversight of Mr M's care for 18 months.

CMHART had limited access to medical support and the waiting list for medical reviews was not managed in line with the Standard Operating Procedure.

Finding 12 - CMHART Management

Serious concerns had been raised internally about the provision of a quality service by Allerdale CMHART.

We have been made aware of high caseloads, high sickness and turnover of senior staff, inadequate supervision, lack of CPA reviews, missed depots, lack of medical staff leading to long waits for medical reviews, and incident reports of a range of concerning HR issues.

Finding 13 - Serious incident review

The internal report was lengthy, overly detailed and went well beyond the

expected Policy timescales.

Family engagement by the lead investigator throughout the initial investigation process was initially very positive, but the Trust has not followed through on the promise to keep in touch about progress.

There is evidence that there are actions in progress to address the recommendations.

Finding 14 - Interagency information sharing

The existing frameworks for information sharing and management of risk were not utilised. The local MAPPA/MARE Policy is overdue for review.

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

North Cumbria CCG has carried out actions in relation to previous recommendations.

Finding 15 - Domestic abuse

In March 2018 there was no routine enquiry by police about the safety of Mr M's parents, after it was reported that his parents had returned his knives because they had felt it was not safe to refuse.

The GP did not make routine enquiries about domestic abuse.

Cumbria County Council managers did not make routine enquiries about domestic abuse.

Trust staff made no enquiries about safety in relation to the family in March or October 2018.

Finding 16 - Domestic abuse local strategy

There is no implementation plan for the current Safer Cumbria domestic abuse strategy.

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

Finding 17 - Matricide

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

Adult child to parent violence and mental illness should be incorporated into domestic abuse strategies.

Recommendation 1
NHS North Cumbria CCG should ensure that referrals for a carer's assessment are made by GPs when carer responsibilities are indicated.

Recommendation 2
Cumbria Constabulary must ensure that where an external referral is made for an adult at risk, the content of the referral must include the relevant detail of the information in the Incident Log and Intelligence Reports.

Recommendation 3
Cumbria Constabulary must ensure that safeguarding plans are created for offenders identified as 'adults at risk' and/or vulnerable.

Recommendation 4
Cumbria Constabulary must develop a clearly defined process for how concerns regarding a person's mental health can be escalated within the force and between other agencies.

Recommendation 5
Cumbria Constabulary must ensure that information regarding individuals convicted of a serious offence, but who are detained under Part Three of the Mental Health Act, is appropriately logged, and managed using the relevant system.

Recommendation 6
The Trust must ensure that for patients on CPA, the GP practice is kept informed of care planning, CPA reviews and developments.

Recommendation 7
The Trust must ensure that evidence-based treatment plans are in place, that are in line with NICE guidance for treatment of psychosis and schizophrenia in adults: prevention and management.

Recommendation 8
The Trust must develop systems that ensure there is consistent monitoring and maintenance of expected standards within the CPA Policy.

Recommendation 9
The Trust must provide assurance that there is a system in place that ensures all patients receive depot medication as prescribed, and that records are made both in the medication chart and the electronic clinical record.

Recommendation 10
The Trust must ensure that there is a comprehensive admission and discharge policy for Yewdale ward which includes care planning, risk management and communication with community mental health teams and family/carers.

Recommendation 11
The Trust must ensure that families and carers are appropriately involved in care planning and risk assessment.

Recommendation 12
The Trust must ensure that referrals for carer's assessments are routinely part of care planning and risk assessment.

Recommendation 13
The Trust must ensure that changes to their risk assessment tools are informed by current research and recommendations from independent bodies. Any newly developed tools should be based on current knowledge and informed by independent experts in risk assessment in mental health services.
They should also be subject to independent evaluation by experts in risk assessment before they are implemented.

Recommendation 14
The Trust must ensure systems are in place to maintain expected standards in clinical risk assessment and planning.

Recommendation 15
The Trust must ensure that there are standards in place for the medical review of patients in Allerdale CMHART, and systems to ensure that standards are maintained.

Recommendation 16
The Trust must ensure that all service users who are prescribed an anti-psychotic have access to an annual medical review, either with a doctor or a non-medical prescriber.

Recommendation 17
The Trust and CCG must provide assurance that the quality and management concerns in Allerdale CMHART have been addressed.

Recommendation 18
The Trust and CCG must ensure that serious incident investigations are carried out at the appropriate levels and within expected timescales.

Recommendation 19
The Trust must provide evidence of assurance of the serious incident investigation action plan implementation, that is then shared with Commissioners.

Recommendation 20
The Cumbria MAPPA/MARE partnership agencies: Cumbria Partnership NHS Foundation Trust*/Cumbria Constabulary/Cumbria Probation Trust/Cumbria County Council Adult Social Care should carry out an update of the current policy, to include audit of whether the MARE process is being used appropriately and including lessons identified in this review.

Recommendation 21
Safer Cumbria and local Community Safety Partnerships should develop systems to ensure there is oversight of the implementation of action plans from Domestic Homicide Reviews.

Recommendation 22
NHS North Cumbria CCG must develop and implement policies to support routine enquiry by GPs about domestic abuse.

Recommendation 23
Cumbria County Council must develop and implement employment policies to support routine enquiry about domestic abuse.

Recommendation 24
The Trust must ensure that risk to families is considered as part of risk assessment and management, with collateral information from family members.

Recommendation 25
The Trust must ensure that where risk to family members is reported, risk assessment must be updated, and victim safety planning becomes part of the risk management plan.

Recommendation 26
Safer Cumbria must develop and implement a comprehensive domestic abuse strategy which includes learning from this review.

Recommendation 27
The Trust must incorporate the understanding of potential risk of harm to parents into risk assessment training, policy, and procedures.

Recommendation 28
The Home Office should incorporate learning about matricide and parricide into domestic abuse prevention strategies.

Appendix A – Terms of reference for the joint review

Terms of Reference for Independent Investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015

The following Terms of Reference for Independent Investigation 2019/1764 have been drafted by NHS England North in consultation and with the agreement of West Cumbria Community Safety Partnership.

The Terms of Reference will be developed further in collaboration with the offeror and affected family members. However, requirements under Appendix 1 above and Domestic Homicides Reviews under the Domestic Violence, Crime and Victims Act published by the Home Office in 2016, are expected to be met for this case.

To identify any areas of best practice, opportunities for learning and areas where improvements to services are required, with a focus on the period from March 2018 to the incident occurring in January 2019.

Involvement of the affected family members and the perpetrator.

- Ensure that the family is; fully informed of the investigation, the investigative process and understand how they can contribute to the process.
- Involve the affected family as fully as is considered appropriate, in liaison with Victim Support, Police and other support organisations.
- Offer a meeting to the perpetrator so that he can contribute to the investigation process.

Care and treatment

- In the absence of the internal investigation report, compile a detailed chronology of contacts and service access.
- Undertake a critical review of the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of their offence - focussing on the period from March 2018 to the incident occurring in January 2019.
- Review the appropriateness of the treatment of the service user and the victim in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family. Comment on how the family's views and concerns were addressed.
- Consider the quality of both health and social care assessments on which decisions were based and actions were taken.

Interagency working and communication

- Establish what lessons are to be learned from the domestic death regarding the way in which professionals and organisations work individually and together to safeguard future victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to required service responses including changes to policies and procedures as appropriate.
- Based on overall investigative findings, constructively review any gaps in inter-agency working and identify opportunities for improvement.
- Explore whether the victim's family had any knowledge of domestic violence by the service user, if so, how was this knowledge acted upon?
- Consider any issues with respect to safeguarding (adults) and determine if these were adequately assessed and acted upon?
- Identify any issues in relation to capacity or resources in any agency that impacted the ability to provide services to the victim and perpetrator and to work effectively with other agencies?
- Was information sharing within and between agencies appropriate, timely and effective?
- Were there effective and appropriate arrangements in place for the escalation of concerns and how were these shared?
- Identify from both the circumstances of the case and the homicide review processes adopted in relation to it, whether there is learning which should inform policies and procedures in relation to homicide reviews nationally in the future and make this available to the Home Office.
- **Risk Assessment**

  Review the adequacy of risk assessments and risk management, including specifically the risk posed to others and how this was shared.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Whether the service user had any previous history of abusive behaviour towards the victim and whether this was known to any agencies.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review.

Review the Trust's assessment of vulnerable carers, who are known to be caring for adults with mental health issues.Serious incident review

- Review the Trust post incident internal investigations and assess the adequacy of their findings, recommendations and action plans.
- Review the progress that the Trust has made in implementing the action plan associated with their internal investigation.

Deliverables

- Provide a final written report to NHS England and West Cumbria CSP (that is easy to

read and meets NHS England accessible information standards) within six months of receipt of all clinical and social care records.

- Based on investigative findings, make organisational specific outcome focused recommendations with a priority rating and expected timescale for completion.
- Share the findings of the report in an agreed format, with the affected family and the perpetrator, seek their comments and ensure appropriate support is in place ahead of publication.
- Deliver an action planning event for the Trust and other key stakeholders to share the report's findings and to provide an opportunity to explore and fully understand the intention behind all recommendations.
- Support the commissioners (where required) in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to those with a legitimate interest.
- In consultation with NHS England, hold a learning event for involved practitioners and services to share the report's findings and recommendations.
- Conduct an assurance follow up visit with key stakeholders, in conjunction with the relevant CCG, 6 months after publication of the report to assess implementation and monitoring of associated action plans. Provide a short- written report, for NHS England that will be shared with families and stakeholder and will be made public.

In addition, the family have asked us to answer these specific questions:

- Who was accountable for the mistakes made in Mr M 's care?
- What has been done about the poor practice of individuals?
- Why didn't they see him at 2pm in January when Len brought Mr M in early for his appointment?
- Why wasn't he given medication then?

Appendix B – Documents reviewed

CPFT/CNTW NHS Foundation Trust documents

- Clinical records.
- Internal investigation report.
- Trust Standard Operating Policy for the Management of Clinical Enablement Structures in CMHARTs (July 2016).
- Incident and Serious Incidents that Require Investigation (SIRI) Policy. May 2019.
- Safe exit for engaged CMHART service users.
- CMHART approach to Service User and Carer involvement 2018 – 2019.
- CMHART Depot Administration - non-attendance flowchart.
- Standard Operating Procedure - Medication expiry date monitoring and management.
- Standard Operating Procedure for Disposing of Unwanted Medication by Community Staff.
- Monitoring and recording temperature of medicines storage.
- Guidelines for High Dose Antipsychotic Therapy.
- Standard Operating Procedure - Physical Health Monitoring for Patients Prescribed HDAT – CMHART.
- Standard Operational Policy (SOP) for the Management of Standard (Non-CPA) Care in Community Mental Health Assessment and Recovery Teams (CMHARTs) December 2016.
- Standard Operational Policy (SOP) for the Management of Access and Referrals in Community Mental Health Assessment and Recovery Teams (CMHARTs) January 2017.
- Standard Operational Policy (SOP) for the Management of Physical Health Clinics in Community Mental Health Assessment and Recovery Teams (CMHARTs) December 2016.
- Standard Operational Policy (SOP) for the Management of Discharges and Transfers in Community Mental Health Assessment and Recovery Teams (CMHARTs) December 2016.
- Standard Operational Policy (SOP) for the Management of Waiting Lists in Community Mental Health Assessment and Recovery Teams (CMHARTs).
- Standard Operational Policy (SOP) for Assessments in Community Mental Health Assessment and Recovery Teams (CMHARTs) December 2016.
- Care Programme Approach & Care Management Policy. August 2018.
- Safeguarding Adults at Risk Policy January 2020.
- Clinical Risk Policy. February 2019

- Other documents
- Individual Management Reports.
- Cumbria Domestic Abuse Strategy 2018 – 2020.
- Multi-Agency Public Protection Arrangements/Multi-Agency Risk Evaluation (MAPPA/MARE) Pathway Policy. January 2017.
- Cumbria County Council Alternative Employment Programme.

Appendix C – NIAF: internal investigation review

Rating	Description	Number
	Standards met	**13**
	Standards partially met	**5**
	Standards not met	**7**

Standard		Niche commentary	
Theme 1: Credibility			
1.1	The level of investigation is appropriate to the incident	The report identifies that it is a root cause analysis investigation report, in accordance with the NHS England Serious Incident Framework, and is a Level 2 investigation.	
1.2	The investigation has terms of reference that include what is to be investigated, the scope and type of investigation	The overall purpose of the investigation is listed and is followed by a detailed list of the terms of reference.	
1.3	The person leading the investigation has skills and training in investigations	The investigation was conducted by an associate investigator employed as the investigating officer (IO) by the Trust, with a consultant psychiatrist as clinical advisor. No information is provided within the report about the skills and training of the psychiatrist in relation to investigations. At interview we established that the IO has professional background as a senior mental health nurse and has extensive training and experience in investigations and organisational governance.	
1.4	Investigations are completed within 60 working days	The homicide occurred on (date) January 2019. The IO received confirmation to proceed on 31 January 2019. The final report is dated July 2019 and was provided to the independent investigation in October 2019. There is no explanation given in the report for the elapsed time.	
1.5	The report is a description of the investigation, written in plain English (without any typographical errors)	The report is very detailed, and densely written but with no significant typographical errors.	
1.6	Staff have been supported following the incident	There is no description of how staff were supported following the incident.	

Standard		Niche commentary	
Theme 2: Thoroughness			
2.1	A summary of the incident is included, that details the outcome and severity of the incident.	There is a summary of the background to the incident, and of the actions after the Trust became aware of the incident.	
2.2	The terms of reference for the investigation should be included.	The terms of reference are included.	
2.3	The methodology for the investigation is described, that includes use of root cause analysis tools, review of all appropriate documentation and interviews with all relevant people.	The report describes the process of the investigation in detail.	
2.4	Bereaved/affected patients, families and carers are informed about the incident and of the investigation process.	The bereaved son and father were met and contributed to the terms of reference. The report was subsequently shared with them and their advocate by the IO and CNTW Executive Director of Nursing.	
2.5	Bereaved/affected patients, families and carers have had input into the investigation by testimony and identify any concerns they have about care.	There is evidence of input from the bereaved family, but not the patient.	
2.6	A summary of the patient's relevant history and the process of care should be included.	A summary of the relevant history and process of care was included.	
2.7	A chronology or tabular timeline of the event is included.	A narrative chronology of care was included.	
2.8	The report describes how RCA tools have been used to arrive at the findings.	The report refers to using the NPSA[114] root cause analysis model but does not explain how the RCA analysis was carried out.	
2.9	Care and Service Delivery problems (CDP & SDP) are identified (including whether what were identified were actually CDPs or SDPs).	No care and service delivery problems are explicitly identified, but different factors are identified.	
2.10	Contributory factors are identified (including whether they were contributory	Contributory factors are not identified.	

[114] *National Patient Safety Agency. https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents*

Standard		Niche commentary	
	factors, use of classification frameworks, examination of human factors).		
2.11	Root cause or root causes are described.	Root causes are described as a list of six, with three of these attributed to the patient.	
2.12	Lessons learned are described.	Lessons learned are not described.	
2.13	There should be no obvious areas of incongruence.	We regard the root causes attributed to the patient as incongruent	
2.14	The way the terms of reference have been met is described, including any areas that have not been explored.	The way the terms of reference have been met is described.	
Theme 3: Lead to a change in practice – impact			
3.1	The terms of reference covered the right issues.	The terms of reference covered the right issues.	
3.2	The report examined what happened, why it happened (including human factors) and how to prevent a reoccurrence.	These factors were covered, however the report reviews care and treatment since first contact which makes the report overly heavy in historical detail.	
3.3	Recommendations relate to the findings and that lead to a change in practice are set out.	There were 36 findings made. There are 10 recommendations, however it is not easy to map these onto the findings.	
3.4	Recommendations are written in full, so they can be read alone.	Recommendations are written in full, so they can be read alone.	
3.5	Recommendations are measurable and outcome focussed.	Recommendations are largely measurable, and outcome focussed. There are however phrases such as ‘should review’ procedures, which are not outcome focussed.	

Appendix D – Family questions

	Family questions	Section
1	Who was accountable for the mistakes made in Mr M 's care?	Section 6 and 9
2	What has been done about the poor practice of individuals?	Section 6 and 9
3	Why didn't they see him at 2.00 pm in January 2019 when Len brought Mr M in early for his appointment?	Section 5: 5.79
4	Why wasn't he given medication then?	Section 5: 5.81

Appendix E – NICE guidance review

Standards	Available to Mr M
Service user experience	
Use this guideline in conjunction with service user experience in adult mental health (NICE clinical guidance 136) to improve the experience of care for people with psychosis or schizophrenia using mental health services, and: • work in partnership with people with schizophrenia and their carers • offer help, treatment, and care in an atmosphere of hope and optimism • take time to build supportive and empathic relationships as an essential part of care.	No. Family not closely involved by the care team as inpatient or CMHART. Lack of care coordinator continuity, limited face to face time with Mr M .
Physical health	
People with psychosis or schizophrenia, especially those taking antipsychotics, should be offered a combined healthy eating and physical activity programme by their mental healthcare provider.	Yes.
If a person has rapid or excessive weight gain, abnormal lipid levels or problems with blood glucose management, offer interventions in line with relevant NICE guidance (see obesity [NICE clinical guideline 43], lipid modification [NICE clinical guideline 67] and preventing type 2 diabetes).	Prescribed statins.
Offer people with psychosis or schizophrenia who smoke help to stop smoking, even if previous attempts have been unsuccessful. Be aware of the potential significant impact of reducing cigarette smoking on the metabolism of other drugs, particularly clozapine and olanzapine.	No evidence.
Routinely monitor weight, and cardiovascular and metabolic indicators of morbidity in people with psychosis and schizophrenia. These should be audited in the annual team report.	Attempts to carry out by the GP, but no evidence of team routine monitoring of results.
Trusts should ensure compliance with quality standards on the monitoring and treatment of cardiovascular and metabolic disease in people with psychosis or schizophrenia through board-level performance indicators.	No evidence.

Support for carers	
Offer carers of people with psychosis or schizophrenia an assessment (provided by mental health services) of their own needs and discuss with them their strengths and views. Develop a care plan to address any identified needs, give a copy to the carer and their GP and ensure it is reviewed annually.	Not offered.

Advise carers about their statutory right to a formal carer's assessment provided by social care services and explain how to access this.	Not offered.
Give carers written and verbal information in an accessible format about: • diagnosis and management of psychosis and schizophrenia • positive outcomes and recovery • types of support for carers • role of teams and services • getting help in a crisis. When providing information, offer the carer support if necessary.	Not offered.
As early as possible negotiate with service users and carers about how information about the service user will be shared. When discussing rights to confidentiality, emphasise the importance of sharing information about risks and the need for carers to understand the service user's perspective. Foster a collaborative approach that supports both service users and carers and respects their individual needs and interdependence.	Not offered.
Review regularly how information is shared, especially if there are communication and collaboration difficulties between the service user and carer.	Not offered.
Offer a carer focussed education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible to all carers. The intervention should: be available as needed, have a positive message about recovery.	Not offered.
Include carers in decision-making if the service user agrees.	Not routinely.

Peer support and self-management	
Consider peer support for people with psychosis or schizophrenia to help improve service user experience and quality of life. Peer support should be delivered by a trained peer support worker who has recovered from psychosis or schizophrenia and remains stable. Peer support workers should receive support from their whole team, and support and mentorship from experienced peer workers.	Not offered.
First episode psychosis standards.	Not applicable.

Subsequent acute episodes of psychosis or schizophrenia and referral in crisis	
Offer crisis resolution and home treatment teams as a first-line service to support people with psychosis or schizophrenia during an acute episode in the community if the severity of the episode, or the level of risk to self or others, exceeds the capacity of the early intervention in psychosis services or other community teams to effectively manage it.	Yes.
Crisis resolution and home treatment teams should be the single point of entry to all other acute services in the community and in hospitals.	No.
Consider acute community treatment within crisis resolution and home treatment teams before admission to an inpatient unit and as a means to enable timely discharge from inpatient units. Crisis houses or acute day facilities may be considered in addition to crisis resolution and home treatment teams depending on the person's preference and need.	Not offered.
If a person with psychosis or schizophrenia needs hospital care, think about the impact on the person, their carers and other family members, especially if the inpatient unit is a long way from where they live. If hospital admission is unavoidable, ensure that the setting is suitable for the person's age, gender and level of vulnerability, support their carers and follow the recommendations in service user experience in adult mental health (NICE clinical guidance 136).	Not offered.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer: • oral antipsychotic medication in conjunction with • psychological interventions (family intervention and individual CBT).	Yes. No.
For people with an acute exacerbation or recurrence of psychosis or schizophrenia, offer oral antipsychotic medication or review existing medication. The choice of drug should be influenced by the same criteria recommended for starting treatment (see sections 1.3.5 and 1.3.6). Take into account the clinical response and side effects of the service user's current and previous medication.	No.
Offer CBT to all people with psychosis or schizophrenia. This can be started either during the acute phase or later, including in inpatient settings.	No.

Offer family intervention to all families of people with psychosis or schizophrenia who live with or are in close contact with the service user. This can be started either during the acute phase or later, including in inpatient settings.	No.
Consider offering arts therapies to all people with psychosis or schizophrenia, particularly for the alleviation of negative symptoms. This can be started either during the acute phase or later, including in inpatient settings.	No.

Behaviour that challenges	
Occasionally people with psychosis or schizophrenia pose an immediate risk to themselves or others during an acute episode and may need rapid tranquillisation. The management of immediate risk should follow the relevant NICE guidelines.	Not applicable.
Follow the recommendations in self-harm (NICE clinical guideline 16) when managing acts of self-harm in people with psychosis or schizophrenia.	Not applicable.

Psychological interventions	
Offer CBT to assist in promoting recovery in people with persisting positive and negative symptoms and for people in remission. Deliver CBT as described in recommendation 1.3.7.1	No.
Offer family intervention to families of people with psychosis or schizophrenia who live with or are in close contact with the service user. Deliver family intervention as described in recommendation 1.3.7.2	No.
Consider offering arts therapies to assist in promoting recovery, particularly in people with negative symptoms.	No.

Pharmacological interventions	
The choice of drug should be influenced by the same criteria recommended for starting treatment.	No.
Do not use targeted, intermittent dosage maintenance strategies routinely. However, consider them for people with psychosis or schizophrenia who are unwilling to accept a continuous maintenance regimen or if there is another contraindication to maintenance therapy, such as side-effect sensitivity.	No.

Using depot/long-acting injectable antipsychotic medication	
When initiating depot/long-acting injectable antipsychotic medication: • take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics) • take into account the same criteria recommended for the use of oral antipsychotic medication (see sections 1.3.5 and 1.3.6), particularly in relation to the risks and benefits of the drug regimen • initially use a small test dose as set out in the BNF.[115]	Yes.

Employment, education, and occupational activities	
Offer supported employment programmes to people with psychosis or schizophrenia who wish to find or return to work. Consider other occupational or educational activities, including pre-vocational training, for people who are unable to work or unsuccessful in finding employment.	No.
Routinely record the daytime activities of people with psychosis or schizophrenia in their care plans, including occupational outcomes.	No.
Consider offering depot /long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: • who would prefer such treatment after an acute episode? • where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan.	No.

[115] *British National Formulary.* https://bnf.nice.org.uk/

Appendix F – Professionals involved

Pseudonym	Role and organisation
CCO1	Care coordinator 1, Band 4 Assistant Practitioner
CCO2	Care coordinator 2, Band 5 Social Worker
SN1	Learning Disability Nurse, duty worker
Dr L	Specialty Doctor, Allerdale CMHART

Appendix G - Action plan review

Summary scores

Recommendation 1	2
Recommendation 2	3
Recommendation 3	2
Recommendation 4	2
Recommendation 5	2
Recommendation 6	2
Recommendation 7	2
Recommendation 8	1
Recommendation 9	1
Recommendation 10	4

Recommendation 1 (a, b, c) The Leadership and culture within Allerdale CMHART was not conducive to the provision of contemporary recovery focused mental health services.		
Trust action plan	**Trust response and evidence submitted**	**Niche comments**
a.The Senior Leadership Team have been working with the Allerdale CMHART to meet the agreed development objectives. b.Individual Allerdale team members should have the opportunity to reflect on their contribution to the care process through clinical and management supervision. c.The Trust CMHARTs should utilise an anonymised version of this report within team learning events in order to ensure that the lessons learnt are discussed and integrated into the Care Coordination process.	HR 'deep dive' into culture & leadership in the team - led to the changes in the leadership positions in November 2019. Dedicated interviews with individual staff members across the service as well as a full team meeting in March 2020 (delayed by Covid). Professional practice investigation commissioned.	Evidence supplied of attendance at individual, group or peer supervision monthly between April and September 2019. The new supervision template is in use. Staff changes show two clinical leads and a clinical manager were moved, and a new experienced operational manager started in August 2020. Example of a new management supervision template, completed May 2020, showed monitoring of key issues. In this anonymised example 7 of the 16 patients had no CPA review recorded. 5 senior leadership focussed workshops between April & August 2019. No outcome shared from professional practice review. Internal report shared with Allerdale CMHART; further learning event planned March 2020 but affected by Covid. It is clear that the Trust identified leadership and management issues in Allerdale CMHART and has made progress in addressing these, with leadership development, personnel changes and revised standards in place. We have not seen evidence of the professional practice review outcomes, or of measured and sustained improvements in practice.
NIAF rating: 2 Action significantly progressed.		

<table>
<tr>
<td>a. The Trust should, within 3 months, review the role of the Associate Practitioner in relation to the core responsibilities of CPA and the professional guidance from the NMC. This should include remedial action to assure the Board that no Associate Practitioner is working in a Care Coordination role with complex individuals outside of their scope of practice.

b.The Trust should ensure all staff undertaking the role of Care Coordinator receive a local induction into their role with immediate effect. This must include a standard for the handover for Care Coordinator responsibility on an intra and inter team basis.</td>
<td>The Associate Practitioner role was reviewed by the service and clarity of expectation of the role was communicated to the individual practitioners and the wider team to ensure that the team was compliant with the assignment of care coordination and CPA responsibilities in line with the grade of practitioner.

Caseloads of Individual Associate Practitioners were reviewed to ensure that the workload was in line with their clinical role and competence. This continues to be monitored via monthly supervision and audit.
Refresher training on CPA within the CPFT policy was delivered to all staff and an audit of caseloads was undertaken as an immediate action.

Since the transition from CPFT to CNTW the service is transitioning from the CPA policy of the former Trust to bring them in line with the standards of care coordination expected under CNTW CPA policy. To support this all staff will be required to receive a refresher training on CPA in line with this transition. Training is currently being rolled out.
CPA standards and expectations of role is discussed as part of the local induction for all staff. (see template). Supervisors are required to discuss CPA requirements as part of the monthly supervision process, and this is recorded in the supervision proforma. The supervision standards are audited monthly and are demonstrating improved performance. This enables the Manager to identify any individual performance issues and these can be addressed in an action plan.</td>
<td>We have been provided with summaries of workload and caseload reviews for Associate Practitioners. The summary report notes that the Team and Clinical Team leads in all CMHART teams have provided assurances that their Band 4 APs have caseloads appropriate to their skills and competencies.
Where there are more complex patients on the Band 4 caseloads, plans are in situ to ensure they have support.

Two audits were provided: March & May 2020. These assessed care plans, GRIST, CPA reviews, HONOS, progress notes and consent. However, they appear to be a report on an individual practitioner each time, rather than a sample audit.
<table>
<tr><th></th><th>March 2020</th><th>May 2020</th></tr>
<tr><td>Care plans</td><td>In date:12 (36%)
Out of date: 21 (64%)</td><td>In date: 26 (87%)
Out of date: 4 (13%)</td></tr>
<tr><td>Grist</td><td>In date & appropriate: 27 (82%)
Out of date: 6 (18%)</td><td>In date & appropriate:27 (77%)
Out of date: 8 (23%)</td></tr>
<tr><td>CPA reviews</td><td>In date & appropriate: 15 (45%)
Out of date: 18 (55%)</td><td>In date & appropriate: 15 (39%)
Out of date: 18 (46%)
Not on CPA: 6 (15%)</td></tr>
<tr><td>Health of the Nation Outcome Scales</td><td>In date & appropriate: 23 (70%)
Out of date: 10 (30%)</td><td>In date & appropriate: 22 (63%)
Out of date: 13 (37%)</td></tr>
<tr><td>Progress notes</td><td>Adequate: 1(3%)
Not adequate: 32 (97%)</td><td>Adequate: 32 (91%)
Not adequate:3 (9%)</td></tr>
<tr><td>Consent</td><td>Yes 12 (36%)
No 16 (49%)
Not recorded 5 (15%)</td><td>Yes 15 (42%)
No 18 (50%)
Not recorded 3 (8%)</td></tr>
</table>
The results in the table show a positive improvement in quality, particularly in care plans, CPA reviews and the quality of progress notes. As a snapshot of a single practitioner’s performance, they offer very limited assurance however.</td>
</tr>
</table>

		We have not been provided with numbers or evidence of attendees for CPA policy refresher training. Local induction template was not provided, and we have not been sighted on any evidence of implementation.
NIAF rating: 3 Action completed but not yet tested		

Recommendation 3 The needs of the parents of the patient were not assessed or fully recognised, despite them requesting support. There was no evidence that they had been offered a Carers Assessment.		
Trust action plan	Trust response and evidence submitted	Niche comments
The Allerdale CMHART should review, within 3 months, how to ensure that a Carers Needs Assessment is offered and facilitated. This should include how the team support families within the CPA framework. An assurance report should be presented to the Triumvirate Management Team within 6 months	Narrative summary: Training on the delivery of carer's assessments was completed with the team supported by the sharing of the Local Authority process for Statutory Carers Assessments. The service has completed a self-assessment against the Triangle of Care Standards and introduced the CNTW "Getting to Know You" process as a routine requirement for each individual service user. Further training around carer/family involvement is being rolled out. The Allerdale CMHART have put in arrangements to invite members of the locality Carer Network to the service meeting in order to share the work that has been undertaken and to promote relationship building. The "Getting to Know You" RiO template and progress note 'carer' option will be embedded into the new RiO version being developed for CNTW. This will allow scrutiny of whether or not carer assessment is being completed. Individual teams to invite their local carer assessment agencies e.g. West Cumbria Carers into team meetings to share the work that they complete, create professional relationships and expand the knowledge of clinicians.	A report (undated) entitled 'CPA' on carer need was submitted, with actions suggested – note there is no functionality in RiO to audit whether all carers are being considered and offered assessment at the point of entry into CMHART teams. The main mechanism for ensuring carer need is being considered occurs within Caseload Management Supervision, which is a monthly recurrence. An audit of the team's compliance with carers assessments was completed and a report submitted to the Feb 2020 Quality Standards meeting. This demonstrated compliance to be at 97.4%. We have not seen the result of the Triangle of Care self-assessment, or any feedback from carers/carer groups on actions taken. Action to raise awareness of carers assessments has taken place, and Allerdale CMHARTs performance in making the assessments has clearly improved. There was no information about improving the involvement of families in CPA care planning.
NIAF rating: 2 Action significantly progressed.		

<table>
<tr><td colspan="3">Recommendation 4 The assessment and management of clinical risk was not robust in relation to the patient's care and treatment, and there was limited assurance regarding the current approach to supporting staff across the organisation.</td></tr>
<tr><td>Trust action plan</td><td>Trust response and evidence submitted</td><td>Niche comments</td></tr>
<tr>
<td>a.The policy in relation to Clinical Risk Assessment and associated training should be aligned to the framework used within NTW from October 2019. This should include a mandatory training requirement for all appropriate CMHART clinical staff to be trained within the next 12 months.

b.A targeted approach in relation to Clinical Risk Training for Allerdale CMHART was initiated post incident by the Senior Management Team. An assurance report will be presented to the Trust Board to demonstrate the impact of this training. The report should include assurance in relation to risk thresholds relating to safeguarding concerns and MARE referral have been addressed.</td>
<td>Refresher training session provided for all staff on Clinical Risk utilising GRiST, the risk tool that was in use across the service at the time of the incident.

Audit was undertaken by Team Leader showed an initial compliance of 33% which required further improvement.

With ongoing audit and discussion in supervision this is now at 87% compliance. Audit data provided as evidence.
As the services in North Cumbria use a different Clinical Risk Tool to the wider CNTW services and that identified in the CNTW Clinical Risk Policy, a paper was presented by SB to the Business Development Group in July 2020 to propose a programme of transition from GRiST to FACE. This has been approved and work has commenced to migrate existing risk data from GRiST in RIO and roll out training on the use of FACE across the clinical team.
Assurance report based on the initial audit findings around compliance with GRiST use completed October 2019.
Recording of risk in relation to MARE concerns was highlighted in the findings and this has resulted in this being a focus of the ongoing supervision discussions to improve overall compliance.
Any individual performance issues were highlighted with the Team Manager and addressed in supervision.

An audit (undated) found that RISK information identified in the GRiST formulation is not accurately captured in the care planning.</td>
<td>
<table>
<tr><td>GRIST</td><td>March 2020</td><td>May 2020</td></tr>
<tr><td></td><td>In date & appropriate: 27 (82%)
Out of date: 6 (18%)</td><td>In date & appropriate:27 (77%)
Out of date: 8 (23%)</td></tr>
</table>
Again, this appears to be a single practitioner's results which is of limited assurance. We have not seen evidence of the audit results showing 87%.

Report to the Business Delivery Group 17 July 2020 regarding changeover from GRIST to FACE.

A report (undated) on assessment and management of clinical risk was submitted as part of the action plan. At that time CMHART held 619 patients, some of whom were undergoing assessment; others were care coordinated under CPA. During the audit process it was identified that 90 clients (14.5%) had GRiST risk assessments over 12 months old and 23 clients (3.75%) had outstanding reviews.
All staff within the Allerdale CMHART have received updated GRiST and Risk Formulation training since the SIRI (with the exception of one clinician who was on leave, but this information has since been shared with the clinician). All staff within Allerdale CMHART received STORM training following the SIRI. In summary, training has been delivered to the team and there are plans for further training. Risk assessment and formulation is being implemented but clinicians are not always transferring the formulation into care plans (where this is appropriate). Timeliness of GRiST update is not meeting expectations/standards- an action plan is suggested that included management monitoring through supervision and quality 'dashboards'.

Audit results (undated) of risk care plans noted, and actions suggested.

Plans are clearly in progress to transition from GRiST to FACE in North Cumbria. The narrative summary shows that the Trust has made the decision to move away from the use of GRIST, and continue to monitor the standard of risk assessments, with structured actions in place to monitor quality.</td>
</tr>
<tr><td colspan="3">NIAF rating: 2 Action significantly progressed</td></tr>
</table>

Recommendation 5 The patient disengaged from service contact and as a result was not seen or monitored regularly in the period before the serious incident. As a result, there was limited, contemporary understanding of his mental health status and a failure to escalate and address his non-compliance with medication in a timely manner.		
Trust action plan	Trust response and evidence submitted	Niche comments
a.The Trust should audit the effectiveness of the depot non-attendance protocol by the end of September 2019. b.The Trust should adopt, with immediate effect, the NTW policy in relation to promoting engagement and ensure all CMHART staff are aware of the expected standards in supporting compliance. c. Monthly case load supervision should include a mandatory criteria to examine all cases of disengagement or medication non-compliance. d.Compliance to core care and risk management plan documentation should be checked at monthly caseload supervision by examination of a random sample of a minimum of 3 cases.	A Standard Operating Procedure (SOP) was introduced re depot non-attendance. A flowchart was produced to support the teams understanding of the SOP and actions to be taken in the event of non-engagement. An audit of compliance against these standards was undertaken within 3 months. A new 'CMHART Depot Administration- non-attendance flowchart' (undated) is in place. An audit trail is to be kept 'CMHART Depot non-attendance audit record'. The supervision document was amended to include this mandatory field, and this is now discussed in monthly supervision. The service has adopted the CNTW policy in relation to promoting engagement across the service and expectations in relation to this policy were discussed with the wider team when the action plan was shared. In individual practitioner supervision sessions, a random selection of three cases are audited routinely by the Team Manager on a monthly basis.	We have not seen the results of the depot audit. The management supervision template included reference to depot compliance, we have not seen results of the management supervision audit. The Trust has developed standards for the management of depot administration, but there is no evidence of improvement yet.
NIAF rating: 2 Action significantly progressed		

Recommendation 6 The patient was not able to access a medical review in a timely manner, in addition there was evidence of wider service pressures associated with high waiting times for Care Coordination. This was in the wider context of the evidence-based fidelity model of AOT no longer being available in Cumbria.		
Trust action plan	Trust response and evidence submitted	Niche comments
a.The medical recruitment and retention strategy should be aligned to NTW with immediate effect, including a review of the mitigation of medical staff shortages within the corporate risk register. b. A detailed workload analysis relating to service demand on the CMHART in Allerdale should be undertaken within 3 months and areas of concern reviewed with service commissioners.	Medical staffing and recruitment strategy for North Cumbria is now aligned to the wider CNTW approach. Where there are issues around shortages, these are addressed by the CBU [Cumbria Business unit] with the Group Directors and escalated appropriately to Business Development Group as required. Allerdale CMHART capacity review report (undated). A full review of the CMHART referrals, waiting list and individual caseloads was undertaken by the Clinical Manager. The findings of this review led to an increase in clinical capacity across the team which had a positive impact on the management of waiting lists and caseloads.	During the period when LS was waiting for a medical appointment, the resident Consultant Psychiatrist at Allerdale CMHART was required to cover gaps in acute inpatient services. Medical time is now fully established, stable and consistent. The waiting times shown as high in 2017/2018. The team have a full time duty worker covering unplanned and urgent work; they also have an assessment team to ensure consistency and a skilled, competent assessment.

Recommendation 7 Discharge from Yewdale ward to the CMHART was not effective in ensuring CPA/Care Coordination/Section 117 responsibilities were met, including continuity of the patient receiving medication.		
Trust action plan	Trust response and evidence submitted	Niche comments
a. Yewdale ward should, within 1 month, review their discharge procedure to ensure compliance to the requirements of Trust policy for CPA, Section 117 and continuity of medication administration. b. The arrangements for discharge from Yewdale ward to CMHARTs should be audited against the updated standards within 3 months to ensure they are effective. Thereafter at 3 monthly intervals for a period of 1 year.	Narrative summary: Substantial work has been undertaken with Yewdale Ward team, CMHART and Crisis Services to improve their discharge planning arrangements and processes to ensure that discharge standards are met and that the process is more coordinated. Yewdale Ward Discharge Audit and Development Plan (2019) show work to review all aspects of the process. The initial audit tool was designed, and the audit undertaken within the 3 months and this demonstrated improvement against all the standards. This is now a monthly audit and the findings are monitored by the inpatient CBU. Audit available as evidence. From a sample of 73 patients on Yewdale Ward and open to CMHART between 1 April 2019 and 29 October 2019, 12 patients had a recorded CPA review while they were on the ward. 4 had a 117 review while they were on the ward. 12 patients had progress note entries that referred to MDT/CPA meetings.	The audit notes that 'The Yewdale discharge audit and development plan will serve to improve communication issues and inter team working. Attainment of CPA and 117 standards will be improved with the plan, but it is unclear if a baseline has been established and it is unclear what the ongoing CPA and 117 audit plan is. The findings of the 73 patients are presented, but without comment on whether these are positive or negative findings. No further audit results were shared. The Trust has developed systems to improve communication and ensure that CMHART are part of planning discharges. We did not see a discharge policy with clear standards and expectations.
NIAF rating: 2 Action significantly progressed		

Recommendation 8 There was confusion between Cumbria Constabulary and the NHS regarding interpretation of the Mentally Disordered Offenders (MDO) protocol post incident. Cumbria Constabulary were not familiar with NHS escalation procedures.		
Trust action plan	Trust response and evidence submitted	Niche comments
a. Work had been initiated prior to finalising this report in reviewing the MDO protocol. The Trust board should seek assurance that the review has been completed to the satisfaction of partner agencies within 3 months. b. An appendix should be included in the revision of the protocol to ensure clarity of escalation procedures in respective organisations.	Narrative summary: Work has been undertaken in relation to reviewing the MDO that operates across North and South Cumbria. It was established that CNTW do not have an MDO protocol in use across the other localities due to Liaison and Custody Diversion teams being in operation. It was also established that the current MDO in Cumbria is used very infrequently by agencies. Discussions regarding the MDO have been into the wider work of aligning processes across the localities that is being picked up through the Trust wide Police and Partner Agency meeting to align processes	No evidence was submitted to support this action.
NIAF rating: 1 Action commenced		

Recommendation 9 The assessment and intervention of the patient's physical health care needs whilst in the CMHART service were challenging.		
Trust action plan	Trust response and evidence submitted	Niche comments
In supporting the principle of parity of esteem the CMHART service should, within 6 months, review its approach to the assessment and intervention of physical healthcare needs and identify areas for improvement.	Narrative summary: Nurse consultant has reviewed the CNTW procedures and processes for managing physical health care within the Community Teams and is supporting the service to align their practices to meet the physical health standards. An initial awareness session has been delivered; Additional staff are being recruited to be dedicated to this function within the team. This will require local induction and additional training for existing and new staff. An overview of the CNTW Physical Health monitoring reports is being provided monthly to ensure team compliance to the standards.	No evidence was submitted to support this action.
NIAF rating: 1 Action commenced		

Recommendation 10 Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 the Trust has a duty to be open and transparent in relation to care and treatment.		
Trust action plan	Trust response and evidence submitted	Niche comments
The outcome of this investigation should be made available to the family of the patient's mother and an apology offered regarding shortfalls in the provision of appropriate standards of care and treatment.	Report author spent time with the family, and with the Executive Nurse visited the family to share the findings of the report on the 11 November 2019. Formal letter of apology has also been sent by the Trust CEO in October 2019.	There is evidence that the Trust has tried to ensure that the family were informed and involved in the investigation. The report was shared with them in person, with time to ask questions and discuss the findings. The family informed us that they felt they were listened to and appreciated the time taken, the apology and assurance of maintaining contact regarding actions.
NIAF rating: 4 Action complete but not yet embedded, impactful		

Appendix H – Thematic review diagram