



INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF Mr X

July 2016

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1 EXECUTIVE SUMMARY

- 1.1** The victim was living with his wife and son, the perpetrator, at the time of his death. The victim was fatally stabbed in his home in Gravesend by his son on 12 September 2011. The victim sustained 10 stab wounds in the attack committed by the perpetrator. The cause of death was stab wounds to his chest and arm.
- 1.2** The perpetrator had a long standing history of schizophrenia. The perpetrator received care and treatment from Kent and Medway NHS and Social Care Partnership Trust ('the Trust'). He was admitted to hospital on 15 occasions between 23 April 1982 and 25 May 2011.
- 1.3** On 1 June 2012, the perpetrator pleaded guilty to the manslaughter of his father, on the grounds of diminished responsibility. A Hospital Order was imposed under Section 37 of the Mental Health Act (MHA) 1983 together with a Restriction Order under Section 41 of that Act.
- 1.4** The victim's death has been the subject of an inquest. The Coroner concluded that 'The victim was unlawfully killed, partly due to an assessment of the perpetrator's mental health not being carried out on the 9th September 2011 or during the weekend that followed'. In addition, the Coroner concluded that on 11 September 2011, a mental health assessment team were not provided with and did not obtain sufficient details of 'the perpetrator's psychiatric history and the risk of harm to the deceased, before they carried out their assessment'.
- 1.5** The Coroner stated that 'The victim's death was avoidable and preventable' as the perpetrator should have been admitted to hospital on or before the 11 September 2011 pursuant to section 2 of the Mental Health Act 1983.
- 1.6** A great deal of learning has already been unlocked for the NHS as a result of the inquest into the victim's death, particularly concerning the period immediately prior to the victim's death when the perpetrator was experiencing a relapse of his illness.
- 1.7** However, in order to understand how the situation which the perpetrator's family found itself in on 12 September 2011 arose, the Independent Investigation Team have sought to understand where that crisis fitted into the perpetrator's overall care and treatment, in order to unlock any further learning for the Trust and the NHS.
- 1.8 Predictable / Preventable**
- 1.9** The Independent Investigation Team have considered the tests of predictability and preventability and have concluded that given the pattern of the perpetrator's illness, his response to medication and the fact that the threats of violence which he made to his father formed part of his illness rather than being due to family dysfunctionality, the death of the victim was predictable and preventable from 17 August 2011 which is when he ceased taking medication and reasonable attempts to seek his re-engagement had failed.

- 1.10** The perpetrator's refusal to take his medication on 17 August 2011 was part of a pattern that had been apparent from June 2010, when he had become non-compliant after a period of relative stability in his illness. The perpetrator had had four admissions to hospital between 5 Oct 2010 and 25 May 2011. Each admission led to stabilisation of mental state with re-establishment on antipsychotic medication, followed by rapid non-compliance and relapse of mental state. This most recent episode of non-compliance should have triggered a strategy discussion involving all parts of the services CMHT (Community Mental Health Team), inpatient teams, and CRHTT (Crisis Resolution Home Treatment Team), which would have systematically examined the risks, the current treatment plan and any alternatives, possibly including consideration of the effective use of mental health legislation. This did not happen.
- 1.11 Failure to consider the perpetrator's care from a long-term perspective**
- 1.12** The NHS is structured to allow individuals with complex health issues to be managed across multiple services throughout entire episodes of care. This has significant benefits. However, there is a danger that it can lead to a loss of a long-term perspective in care delivery, with each team concentrating on the particular function of that part of the service, and not considering the overall course of the patient's illness over time.
- 1.13** The Independent Investigation Team have reached the view that a significant feature of the perpetrator's care was a failure to take a long-term view of his condition during the period between 2 March 2011 and 12 September 2011. His care appears to have been delivered as a response to individual acute episodes rather than a desire to achieve treatment goals which would improve the perpetrator's quality of life whilst he coped with a chronic illness. This could also have had an adverse impact upon his compliance with his care and treatment and the failure to understand the risk which he posed to himself and others.
- 1.14** Contained within the perpetrator's medical records is a large volume of documentation generated by the CPA (Care Programme Approach) process. The Independent Investigation Team readily acknowledges that a substantial amount of time and resources has been applied to comply with Trust protocols surrounding completion of these documents. However, rather than representing a vehicle for promoting the perpetrator's care and delivering him with a plan and care package designed to meet his individual needs at each stage in his care, the documentation appears only to deliver a plan which is process derived and driven, rather than focussed upon the perpetrator's needs in order to promote his long-term care.
- 1.15 Failure to consider the family dynamics in a non-judgemental fashion**
- 1.16** Living with an individual who has a severe mental illness can be challenging.
- 1.17** It is of fundamental importance, therefore, that the professionals who deal with the families of individuals with chronic mental health issues demonstrate a genuine understanding of what it is like to live with a severe mental illness and try to connect with this experience when carrying out their duties.

- 1.18** The reason for this is not simply to prevent families being seen as a problem, but instead to ensure that the opportunity which they represent for clinicians as a resource and means of significant knowledge in relation to the individual who is ill, can be exploited.
- 1.19** In this case, the perpetrator's family were part of the solution to understanding aspects of the perpetrator's presentation. There was a direct correlation between family disharmony and the perpetrator's mental health. There is no evidence in the perpetrator's medical records to suggest that he acted aggressively or violently towards his father except when he was ill. This was brought to the attention of clinicians repeatedly by his family. However, instead of this issue being explored sensitively and systematically, judgements were made, often without any secure foundation, which may have been unhelpful.
- 1.20** In failing to review the complaints about disharmony in the perpetrator's family systematically, rather than judgementally, clinicians missed a significant opportunity to exploit knowledge which in turn could have been of diagnostic and therapeutic benefit for the perpetrator, his family and services.
- 1.21** The impact of this cannot be underestimated. The change in emphasis as to the cause of the perpetrator's aggression towards his father, from it arising from the perpetrator's illness to the cause of the violence being issues in the family dynamics, led to subsequent underestimation of the level of risk posed by the perpetrator during periods of relapse, which is particularly evident during the admissions of March 2011.
- 1.22 Poor understanding of Perpetrator's illness**
- 1.23** The perpetrator's illness followed a recurrent pattern through 15 separate admissions to hospital. Significant features of his illness included his lack of insight and his failure to take his medication, leading to relapse and disengagement with services. This may have been because either he felt well, or that his illness causes issues with compliance and violence/aggression which was aimed at family members, particularly his father, which was not a feature of the perpetrator's behaviour when he was well.
- 1.24** There was a lack of recognition on the part of those caring for the perpetrator in 2011 that, following a period of relative stability, including compliance with his depot medication between 2007 and 2010, the perpetrator's illness appeared to enter a new and malignant phase from the end of 2010, with a repeated pattern of non-compliance and relapse.
- 1.25** When this pattern became apparent, it should have triggered a systematic review of the perpetrator's care. This should have included a review of the historical data, an examination of the management plan to determine if there were alternative approaches to put in place, and the development of a contingency plan to provide guidance and advice to family and clinicians about actions to be taken in the event of signs of relapse becoming evident.

- 1.26** If such a review had taken place, those responsible for the MHA assessment in September 2011 would have been in a better position to make an informed decision about the risks posed by the perpetrator.
- 1.27 Understanding the risks which the perpetrator posed when ill**
- 1.28** The perpetrator underwent a review by a Forensic Psychiatrist in 1995.
- 1.29** This Review was comprehensive. It recognised:
1. A link between the perpetrator's failure to comply with his medication and relapse of his condition.
 2. The risk which a relapse might pose to those around him.
 3. The manner in which care might best be delivered to the perpetrator.
- 1.30** Repeatedly throughout the course of the perpetrator's care and particularly in relation to the period between 2 March 2011 and 12 September 2011, historic data in the form of the perpetrator's paper and earlier digital records was not systematically reviewed to help formulate a treatment plan or risk assessment which was tailored to suit the perpetrator's needs.
- 1.31** This is disappointing, as the historical information clearly indicated the high degree of risk presented by the perpetrator when experiencing a relapse. In the absence of the systematic review of this data, the treatment plans and risk assessments were incomplete.
- 1.32** This failure had an impact not only upon his care at the time, but it meant that the results of such reviews would not have been included in his notes. Had a review taken place which pulled together all of the information in the paper and electronic records, that information would have had a greater chance of coming to the attention of those who saw the perpetrator between 9 and 12 September 2011.
- 1.33 Failure to adhere to the ethos of the Care Programme Approach**
- 1.34** There was no evidence of the various components of the acute service acting together in a coherent way to take an over-arching and long-term view about the perpetrator's care.
- 1.35** The acute care components of the service, including acute inpatients and CMHT, did not appear to work together to develop a comprehensive management plan which would have addressed relapse prevention strategies, crisis planning, psychological approaches and support for the family.
- 1.36** It is disappointing that neither Community Consultant 1 nor Care Co-ordinator 1 viewed the opportunity of a CPA meeting as being an event which could deliver long-term care and potentially avert a crisis. Even if a crisis could not have been averted, a CPA meeting held on 17 August 2011 could have better informed those who became responsible for the perpetrator's care between 9 and 11 September 2011.

1.37 Medical records

- 1.38** The perpetrator's medical records were lengthy. However, had systemic reviews been conducted throughout his care, the risk of important information being absent would have been prevented and this information would have been documented in the records.
- 1.39** Those providing support and care for family members with a lengthy history of mental illness would have no reason to suspect that medical professionals would not have access to that individual's full medical history, as was the case with the perpetrator.
- 1.40** The MDT (Multi-Disciplinary Team) in place when this incident occurred, who are currently employed within the Trust, are sensitive to and aware of the failures in process and communication that played a crucial role in this case. With the passage of time and changes in staff there are fundamental flaws in the migration of patients' medical history that have not been addressed by the Trust. Without the implementation of a strategy for meaningful engagement with carers, there remains the potential for an inaccurate risk assessment in cases similar to this one. For instance, where a patient with an extensive medical history who has been well for a period of time is assigned to a newly appointed consultant, the consultant may be unaware that medical records must be accessed in multiple formats. This could result in a flawed risk assessment with serious consequences, as have been demonstrated in this case.

1.41 Trust response to carer inclusion

- 1.42** Throughout the perpetrator's illness it was apparent to members of the Independent Investigation Team that the perpetrator received considerable support from his family, however, the inclusion of carers in the care of service users was not part of an embedded culture within the organisation.
- 1.43** Accounts given by the family of the perpetrator's behaviour and its impact upon their lives were treated with suspicion, statements made by the perpetrator at a time when he was clearly unwell were accepted as fact, and no attempt was made by those responsible for the perpetrator's care to establish the true facts of the situation; they were, over time, accepted as the dynamics that existed within the family.
- 1.44** The victim was persistently denied the opportunity to have his views heard and to express the fear he shared with his daughter that 'they will do something when he kills me'.
- 1.45** This response reflects the problems which patients face in obtaining a long-term approach to their care. The patient remains constant, the carers remain constant, but because the organisations change, difficulties arise. It is these difficulties which the Triangle of Care seeks to resolve. This is disappointing.
- 1.46** The Independent Investigation Team believe there are practical steps which can be taken to help this situation:

- Advance directives should be offered to all people with severe mental illness to help manage treatment preferences when a person becomes unwell.
- Consent to share information should be updated regularly to promote effective communication between practitioner, the person and family members.
- Carers should always be given a contact point to access the mental health system in a crisis.

1.47 Reaction to the incident by healthcare providers

1.48 The Independent Investigation Team note that the Trust conducted an Internal Investigation concerning the immediate period prior to the death of the victim. Learning for the Trust was achieved from that review concerning the Trust's response to the crisis situation in which the perpetrator found himself in September 2011.

1.49 In addition, the Independent Investigation Team are concerned that the Trust did not look more widely in relation to the perpetrator's care to determine how that crisis could have been avoided or handled differently, and concentrated upon the crisis situation which arose between 9 and 11 September 2011 rather than considering why the crisis arose in the first place.

1.50 Further, as the Independent Investigation Team has sought to demonstrate, there is still considerable learning for the Trust arising out of the perpetrator's care if a less restrictive view than simply the events of 9 and 11 September 2011 is considered.

1.51 Recommendations

1.52 In order to provide an insight into the direction of the report at a glance, an overview of the Independent Investigation Team's recommendations is as follows:

Recommendation 1 – Improving Long-Term Care

1. The Trust further develops its supervision policies and procedures to facilitate supervision being used to promote the delivery of patient centred long-term care.

2. The supervision process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of patient care viewed from a long-term perspective.

3. Regular audits take place to demonstrate that the supervision chain is identifying and addressing any deficiencies in the quality of care being delivered to patients.

Recommendation 2 – Building Relationships with Carers

1. In order that those treating an individual with a longstanding mental health condition obtain a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics of an individual, the Trust's Quality Assurance Programme should be revised to ensure that Teams are required to constantly monitor and review their relationship with individual patient's carers with a view to maximising the value of the information and knowledge which carers can provide.

2. The effective implementation of this recommendation be monitored within the Team Supervision Process as outlined above in Recommendation One.

3. The standard practice of clinical teams in relation to this recommendation is monitored by periodic audit.

4. Collateral histories should be taken from carers to secure a greater insight into a patient's situation and those of the carers themselves.

Recommendation 3 – Responding to the Patient's Needs

1. The Trust should reinforce the position of patient centred clinical care as the cornerstone of care management in delivering services. The essentials of this are contained within the Trust's CPA policy and includes the systemic review and sharing of clinical information to inform clinical decision-making, and the management of risk.

2. The ethos of CPA should be reflected and strengthened in the training programmes that staff are required to attend, and the priorities identified in individual and group supervision.

3. Supervision should include routine review of actual cases to ensure the appropriate application of the principles and ethos of CPA have been addressed and to enable corrective action to be taken if required.

4. The implementation of this Recommendation should be monitored by periodic audit.

5. The Trust's Quality Assurance Programme should be revised to ensure that Care Plans reflect a comprehensive understanding of the ethos of CPA in order that current psychiatric, social, family circumstances and risk characteristics of the individual they are treating are addressed and that individual patient centred care can be delivered.

Recommendation 4 – Information contained in Medical Records

1. Until a strategic response is implemented by the Trust, a protocol is developed to ensure that a review of records across paper and electronic records upon patients who have experienced a number of episodes of care is undertaken at an early stage in relation to a new inpatient admission or CPA

review upon discharge or transition from one service to another.

2. The performance of this requirement and adherence to any protocol be monitored and audited.

3. These audits form part of regular Clinical Governance Team Meetings.

Recommendation 5 – Working With Carers

1. Advance directives should be offered to all people with severe mental illness to help manage treatment preferences when a person becomes unwell.

2. Consent to share information should be updated regularly to promote effective communication between practitioner, the person and family members. Protocols and policies should be introduced to secure this.

3. Carers should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.

4. The Trust review its carer's strategy to ensure that carers receive appropriate psychological as well as practical support.

Recommendation 6 – Learning from Adverse Events

1. In order to maximise the learning from significant events such as the perpetrator's fatal attack upon his father, an approach is adopted which seeks to understand the bigger picture rather than adopting a restrictive approach. For example investigating how a crisis has developed as a means to identifying whether there was a greater opportunity for the learning which can generate improvements in service delivery. The Independent Investigation Team recommends that the Trust's Framework for investigating such incidents be reviewed to implement this recommendation.

2. The Trust takes active steps to ensure that staff and clinicians are supported in relation to adverse events.

3. The Trust must implement processes to ensure that the learning from adverse incidents and the action points which are generated are drawn to the attention of staff and clinicians involved in the events in order that learning can be embedded in the day to day practices of those responsible for delivering care.

2 INTRODUCTION

- 2.1 The victim was living with his wife and son, the perpetrator, at the time of his death. Although he was 71, he was able to work and provide for his family as he had done all his life.
- 2.2 The victim was fatally stabbed in his home in Gravesend by his son on 12 September 2011. The victim sustained 10 stab wounds in the attack committed by the perpetrator. The cause of death was stab wounds to his chest and arm.
- 2.3 The perpetrator had a long standing history of schizophrenia. The perpetrator received care and treatment from the Trust. He was admitted to hospital on 15 occasions between 23 April 1982 and 25 May 2011.
- 2.4 On 1 June 2012, the perpetrator pleaded guilty to the manslaughter of his father, on the grounds of diminished responsibility. A Hospital Order was imposed under Section 37 of the Mental Health Act 1983, together with a Restriction Order under Section 41 of that Act.
- 2.5 At an inquest hearing on 1 October 2014, the Coroner concluded that the victim was 'unlawfully killed partly due to the assessment (*sic mental health assessment*) not being carried out on 9 September 2011 or during the weekend that followed and that on the 12 September 2011 the (*sic mental health*) assessment team were not provided with and did not obtain sufficient details of the perpetrator's psychiatric history and the risk of harm to the deceased before they carried out their assessment'. On the balance of probabilities, and on the evidence, the victim's death was said by the Coroner to be avoidable and preventable as the perpetrator should have been admitted to hospital on or before 12 of September 2011, pursuant to section 2 of the Mental Health Act 1983.
- 2.6 The victim had held longstanding concerns about his son's care and the risk which it posed to him. On the day of his death he had remarked to his wife 'they will do something when he kills me'. The Independent Investigation team hopes that the family and friends of the victim and the perpetrator will find this report helpful in addressing their questions and concerns in relation to the care which the perpetrator received, as well as providing learning for the NHS.

3 PURPOSE OF REPORT

- 3.1** In the period between 2 March 2011 and 12 September 2011, the perpetrator was in contact with services delivered by the NHS, including mental health services. As a result, NHS England have commissioned an Independent Investigation report in accordance with HSG (94) 27 and the NHS England Single Operating Model in order to maximise the learning for the NHS from the tragic death of the victim. This report sets out the findings of the Independent Investigation Team.
- 3.2** The aim of the Independent Investigation Team in conducting this Investigation is to improve the delivery of mental healthcare services for individuals such as the perpetrator who suffer from schizophrenia, and for the individuals who are more closely connected with them.
- 3.3** In many ways, the manner in which the perpetrator presented to mental health services is neither uncommon nor indeed remarkable. What is remarkable, however, is the tragic death of the victim.
- 3.4** The perpetrator had been admitted to hospital either voluntarily or pursuant to the Mental Health Act for treatment of his schizophrenic illness on 15 occasions. It is clear from his history that each time the perpetrator ceased to take his medication the outcome was a relapse of his illness. The perpetrator complained of side effects as a result of the medication which he took for his illness, which he used as one of two reasons to explain his reluctance to take his medication. The other reason was that the perpetrator believed that he was well; that he had recovered following his treatment.
- 3.5** Whilst some individuals can be violent or aggressive independent of whether they are experiencing positive psychotic symptoms as part of an illness, this was not the case with the perpetrator. The violence which the perpetrator exhibited towards his father was directly related to his psychotic symptoms, and was therefore a feature of his illness. There is no evidence to suggest that when the perpetrator was well he acted aggressively or violently.
- 3.6** The Independent Investigation Team hope that this report will allow care providers an opportunity to reflect upon the care which the perpetrator received with a view to making improvements for future service users and those who come into contact with them. In this way, it is intended that some benefit can be gained from these tragic events, and a degree of comfort achieved for those whose lives were affected by the victim's death.
- 3.7** The Terms of Reference of the Investigation, Team Membership, the Chronology prepared during the course of the Investigation, and a glossary can be found at Appendices A to D.

4 VICTIM IMPACT STATEMENT

- 4.1 The death of the victim lies at the heart of this Independent Investigation. He had voiced concerns about the care which his son was receiving and was worried about his own safety.
- 4.2 In order to give the victim a voice in the Investigation into his son's care and to allow members of his family to express how his death has had an impact upon their lives, the Independent Investigation Team asked his daughter to explain their loss.
- 4.3 *My dad was a kind, gentle, placid, generous, loving family man who would not hurt a fly. His main priority in life was his family and their welfare. A very happy smiley contented gentleman who was liked and loved by all that knew him.*

There is not a day goes past when I do not think about my dear gentle dad. I know if he was still here our family would still be together. My dad has missed out on being a great grand-dad to [his great grandchildren]. I am also missing out on being their nanny through all the family dynamics within the family which has occurred since the circumstances surrounding the death of my father. My relationship with the perpetrator has now resumed but I still find it very difficult on an emotional level.

I still cannot believe this has happened. Two days after the passing I had to identify my dad's body. I will never forget the way he looked, I was so shocked, that beautiful smile had gone and this will live with me forever. All I have now is the memories. I have flash backs of the night this happened, even though I was not there and still cannot really come to terms with.....why?

In my opinion in the eyes of the authorities my dad did not exist, this is evident by the lack of involvement in the years of [the perpetrator's] documented treatment. Well he does not exist now.

I really do hope that lessons will be learnt from this sad, tragic event. But I doubt it. I feel that from Board Level to the newest AMHP are arrogant and fail to comprehend the impact that their inability to do their job has had on so many lives. The authorities deluded and naive approach to the care of my brother and their unprofessional consideration and duty of care towards my dad have robbed me of my father, my brother, my mother, my three children and my three Grand-children and the only thing I have left are the beautiful memories of a kind, loving gentle man who gave his love and friendship to all that knew him.

5 INVESTIGATIVE APPROACH

- 5.1** The Independent Investigation Team regards a successful outcome to an Independent Investigation as being changes in how an organisation thinks or works as a result of learning which is unlocked from a tragic incident such as the death of the victim. Changes in practices, however small, can dramatically change the quality of service delivery.
- 5.2** The Independent Investigation Team is aware that this case has already been the subject of an inquest. The inquest focussed upon the period between 9 September 2011 and 12 September 2011, at a time when those most closely connected with the perpetrator were concerned that he was experiencing a crisis.
- 5.3** During the course of the Inquest, extensive submissions were made to the Court by the Trust concerning changes to practice which had been made by the Trust as a result of this incident.
- 5.4** A substantial amount of learning has been achieved through the consideration of the period between 9 September 2011 and 11 September 2011 as to how the Trust responded to the perpetrator's crisis.
- 5.5** However, in order to unlock further learning for the Trust and the NHS, the Independent Investigation Team have sought to understand whether the care which the perpetrator received in the months leading up to 12 September 2011 could have had an impact upon the response which clinicians made to the relapse of his psychotic illness between 9 and 11 September 2011. In order to do this, the Independent Investigation Team concentrated upon the period between 2 March 2011 and 12 September 2011.
- 5.6** The death of the victim is a catastrophic event which has had a continuing effect upon his friends and family and indeed the perpetrator. In order to ensure that proportionate and meaningful learning is unlocked concerning the healthcare which the perpetrator received in the period leading up to the death of his father, the Independent Investigation Team have taken into account that knowledge of the outcome can unconsciously colour ideas of how and why an adverse incident occurred.
- 5.7** Hindsight bias promotes the belief that adverse events are more foreseeable and more avoidable than they actually are. Moreover 'errors' in the chain of events can assume greater importance with the knowledge of the outcome. This can result in participants in adverse events being blamed and inappropriate lessons being learnt from the Investigation. To a retrospective observer all the lines of inquiry can home in on the end result; but those individuals who were on the spot did not have the benefit of foresight.
- 5.8** However, in order to ensure the greatest amount of learning for the NHS, the Investigation Team have taken the recurrent pattern of the perpetrator's illness into account, as it is directly relevant to the response which those who were responsible for his care made or indeed could have made. In this sense 'hindsight bias' has been used as a positive tool in order to unlock further learning for the NHS in this case.

6 LEARNING FROM PREVIOUS MENTAL HEALTH HOMICIDES

- 6.1** Christopher Clunis had a long history of psychiatric illness, including previous displays of violent behaviour, before he killed Jonathan Zito, a musician, in an unprovoked attack at a London underground station on 17 December 1992.
- 6.2** His care was described as a ‘catalogue of failure and missed opportunity’ by the Ritchie Inquiry which had been tasked with reviewing Mr Clunis’ care. The Ritchie Inquiry found that ‘the more disturbed Christopher Clunis became, the less effective was the care he received’.
- 6.3** The Ritchie Inquiry identified a string of failures by the mental health professionals involved in the care of Mr Clunis. These included a failure to:
- Achieve proper communication and liaison.
 - Assess Clunis’ past history of violence and his propensity for violence.
 - Manage provision of health and social services.
 - Note and act upon warning signs and symptoms to prevent relapse when a patient is living in the community.
- 6.4** The Ritchie Inquiry found that hospitals and social services also failed to contact Mr Clunis’ family or GP, repeatedly treated admissions as separate incidents, and discharged him from hospital when he was not ready, because of pressure on beds, or to save money.
- 6.5** The Inquiry team said, ‘We do not single out just one person, service or agency for particular blame. In our view the problem was cumulative; it was one failure or missed opportunity after another’.
- 6.6** Since 1992, significant changes have been made to the legal framework governing mental health and there have also been changes in the manner services are delivered. However, analysis of mental health homicide reports since the Ritchie Inquiry into Mr Clunis’ care, show that the issues highlighted in that report remain a persistent and common feature in the findings of Independent Homicide Investigation Teams from around the country.
- 6.7** The landscape of mental health provision is far more complex than when the Ritchie Inquiry was written. The Ritchie Inquiry led to a movement towards ensuring that there were systems and processes and ensuring that there were proper processes in place to address the type of failings which were noted to have occurred in the care of Christopher Clunis. This may not have been the intention of those who wrote the Ritchie Report but it is how that Report’s recommendations have been interpreted and implemented by some organisations.

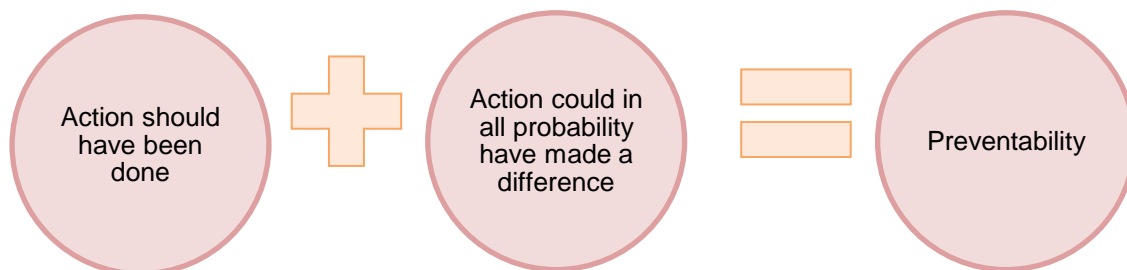
- 6.8** The Francis Inquiry report was published on 6 February 2013 and examined the causes of the failings in care at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The report made 290 recommendations. The Francis Inquiry was significant because it stated that the quality of patient care is central to service delivery and in doing so encouraged the move away from a systems based culture which has evolved in some areas of the NHS.
- 6.9** The Francis Inquiry requires NHS organisations to re-evaluate their approach to care. In essence following the Francis Inquiry it is not sufficient simply to have a system or process in place to deliver care; it is the quality of the care to be delivered that is important. Consequently, in order to develop a culture that places care at its heart, individuals are required to consider the quality of care which is being delivered, rather than simply delivering and adhering to a policy which may not address the needs of an individual patient. In essence, professionals can operate a system which their organisation requires of them but this may not be enough, if it does not deliver patient focussed care.
- 6.10** The Ritchie Report and the Francis Report both have direct relevance to the care of the perpetrator. The Independent Investigation Team recognises that the events which are the subject of this report took place prior to the conclusion of the Francis Inquiry. However, a core purpose of the CPA implemented in response to the Ritchie Report, is to provide a framework for care planning which recognises the needs of the individual and in that sense both reports place the needs of the individual at the heart of service delivery.

7 PREDICTABLE / PREVENTABLE

- 7.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the victim's death was predictable or preventable.
- 7.2 Many independent investigations identify failings, missed opportunities or gaps in the care which an individual was provided. However, this does not mean that a homicide could have been either predicted or prevented.
- 7.3 The following tests are commonly applied to determine whether a homicide could have been predicted or prevented.



- 7.4 A homicide is predictable if there was evidence from the perpetrators words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.



- 7.5** A homicide could have been prevented if there were actions that healthcare professionals should have taken, but which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken, or opportunities which were missed would not provide evidence of preventability, as there are always things that could have been done better.
- 7.6** The Coroner stated that 'The victim's death was avoidable and preventable as the perpetrator should have been admitted to hospital on or before the 11 September 2011 pursuant to section 2 of the Mental Health Act 1983'.
- 7.7** The Independent Investigation Team have applied the tests of predictability and preventability set out at paragraphs 7.0 to 7.5 above, to the events of 11 September 2011 and have reached a similar view to the Coroner, in that the victim's death was both predictable and preventable at that time.
- 7.8** However, in order to maximise the learning from the perpetrator's care, the Independent Investigation Team have also considered these tests in relation to the period 2 March 2011 to 12 September 2011 to understand when, in the timeline of the perpetrator's care, the homicide of his father could have been predicted or prevented in an attempt to promote further learning.
- 7.9** The medical evidence submitted to the Court during the course of the perpetrator's trial suggested that at the time of his father's death he was suffering from paranoid schizophrenia, which constitutes a serious mental illness.
- 7.10** The belief that people who suffer from schizophrenia are dangerous is as common and widespread as it is misconceived. The media often depicts mentally ill individuals as violent and out of control which encourages stigmatisation. However, the statistical reality is that most people who suffer from schizophrenia are no more prone to violence than anyone else. Indeed there is evidence to suggest that people who suffer from schizophrenia tend

to be socially withdrawn and would rather not engage with others and may be more likely to be a victim of crime than becoming a perpetrator.

7.11 There are, however, factors which are predictors of violence or may play a role in violent behaviour exhibited by some individuals who are experiencing a serious mental illness such as schizophrenia. These general factors are:

1. A history of previous violent behaviour;
2. Failure to take medication;
3. Disengagement from services;
4. Certain types of delusions, particularly ones which are both persecutory and grandiose;
5. Command hallucinations which tell them to harm others;
6. Substance or alcohol misuse or addiction.

7.12 The Independent Investigation Team recognises that if an individual has a history of violent actions then they are more likely to commit violent acts in the future. In most cases, the violence exhibited by an individual is likely to mirror the way in which they had been violent or aggressive before. This includes the group of individuals to whom the violence is directed.

7.13 During his sixth admission to hospital, the perpetrator underwent a review by Forensic Psychiatrist 1. This review is set out in a report dated 21 December 1995. The perpetrator had been admitted to hospital following an attempt to stab his father on or around 14 October 1995.

7.14 The Independent Investigation Team regards this review as comprehensive. It recognised:

- A link between the perpetrator's failure to comply with his medication and relapse of his condition;
- The risk which a relapse might pose to those around him;
- The manner in which care might best be delivered to the perpetrator.

7.15 Significantly, it included the following observations about the perpetrator's presentation:

'[the perpetrator] is a 32 year old man suffering from paranoid schizophrenia, who has had three worrying aggressive episodes in the last five years. All three of these episodes seem to be in response to active psychotic symptoms. The present recurrence of his illness appears to be the result of his medication being reduced. [the perpetrator] reports that the second episode when he hit his father also occurred after his medication had been reduced.'

'He is currently well and I believe when well presents little or no risk of violence. When he is psychotic he obviously presents a significant danger of violence especially to members of his family.'

I agree with your rehabilitation plan in that he is first to go on leave from hospital and everyone involved in his care will be made fully aware of his needs to take medication and the necessity to alert

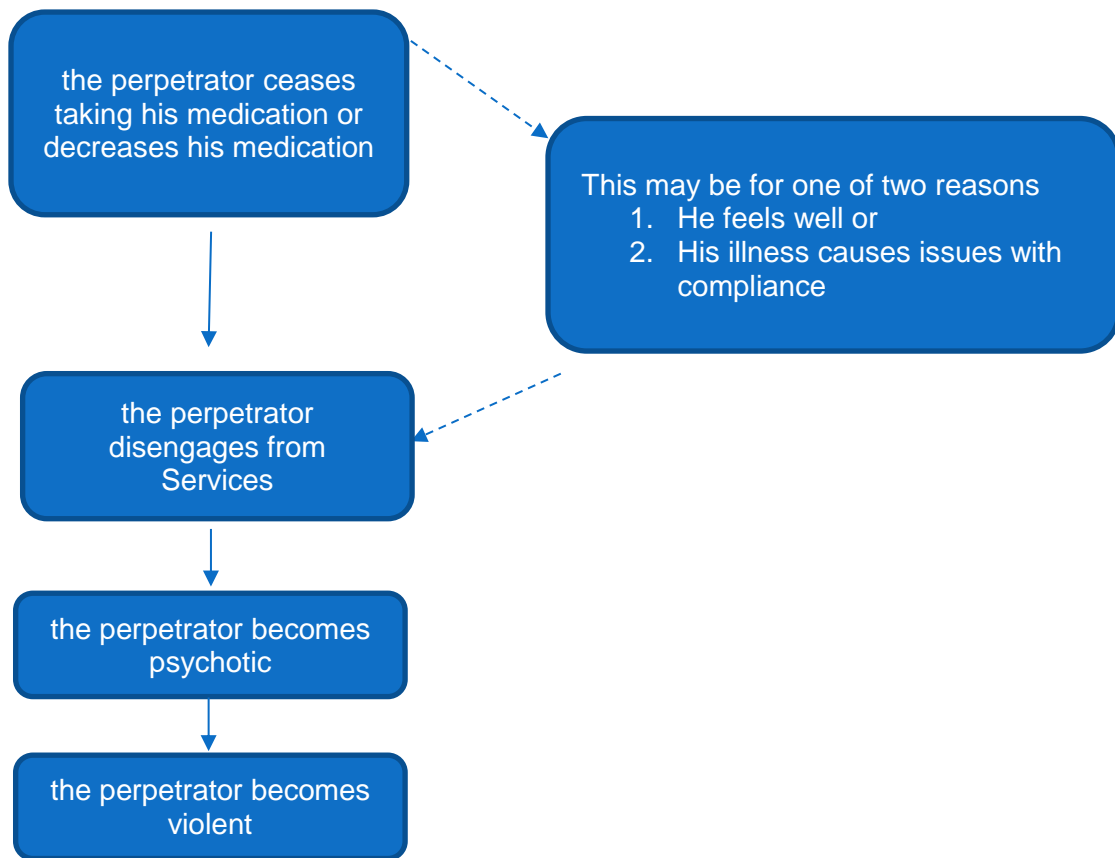
health care professionals should he show early signs of becoming unwell or become non-compliant’.

7.16 The report went on to state that:

‘It appears that [the perpetrator’s] relapses of psychotic illness are related to a decrease in the amount of medication he takes. There is some question as to whether this is due to him being prescribed less medication or [the perpetrator] feeling that he is well and no longer becoming compliant.As far as I am aware he has suffered no side-effects from his medication and it seems he would be happy with this plan’.

7.17 The Independent Investigation Team have noted that throughout the course of his admissions to hospital, following this time, the perpetrator’s pattern of illness remained constant:

7.18 Following the forensic report dated 21 December 1995, there were a number of other significant incidents of violence against the victim committed by the perpetrator when he was experiencing a crisis. On 26 April 2000, the perpetrator refused all medication except for antidepressants, leading to a deterioration in his mental health. On 15 June 2000, he was admitted to the psychiatric unit, having not had a depot injection for seven weeks. The perpetrator had become hostile towards his father and admitting holding a knife to him, but said 'I would not have hurt him'. As the perpetrator lacked insight into his condition, he was admitted under Section 3 of the Mental Health Act 1983. The perpetrator was discharged on 12 July 2000.



7.19 On 23 June 2007, a verbal argument occurred when the perpetrator refused to take his medication. The perpetrator then became aggressive and pushed his father a number of times until his father fell onto the floor, hitting his arm on the fireplace causing injury. The perpetrator's parents then tried to escape upstairs to telephone the Police. The perpetrator followed his parents and barged into the bedroom and stopped them from using the telephone. The perpetrator was subsequently arrested for assault occasioning actual bodily harm.

7.20 On 11 August 2007, the perpetrator threatened his father with a knife and punched him on the nose. This was following an argument about the perpetrator refusing to take his medication for a psychotic illness. The

perpetrator was arrested for assault occasioning actual bodily harm. He was admitted to hospital shortly after.

- 7.21** On 9 March 2011, the perpetrator held a knife above his father's head. The perpetrator had refused to take his medication.
- 7.22** In addition, there are a number of reports in the perpetrator's records of verbal aggression towards his father during periods when he had ceased taking his medication. One such entry is dated 5 October 2010.
- 7.23** The Independent Investigation Team carefully considered the instances of violence committed by the perpetrator. The violence is most commonly exhibited against his father although it could also be directed at others. The historical evidence clearly indicates that, as had been noted in the forensic report of 1995, violence directed by the perpetrator towards others, particularly his father, was a feature of relapse of his illness and was not present when his condition was stable. There is no evidence to support the belief that his aggression was related to dysfunctional or difficult family relationships. As a result, the Independent Investigation Team considers the violence to be a feature of the perpetrator's illness rather than being due to relationships within the family.
- 7.24** The Independent Investigation Team have considered the tests of predictability and preventability set out at paragraphs 7.0 and 7.5 above and have concluded that, as a result of the consistent pattern which the perpetrator's illness took, it was predictable that the perpetrator would carry out a significant act of aggression upon his father if he was experiencing psychotic symptoms in the absence of medication. This possibility was highlighted in the perpetrator's records as early as 14 October 1995, as was his use of knives, and consequently the Independent Investigation Team believe that a significant attack upon the victim was predictable should the perpetrator become psychotic and fail to take his medication.
- 7.25** In addition, because the perpetrator's illness followed a regular pattern, where following appropriate treatment using medication, the perpetrator's psychosis would respond to treatment, then the death of the victim could have been prevented.
- 7.26** The Independent Investigation Team believe that had a proper review of the perpetrator's care been undertaken as set out in Paragraph 12.9, it would have been clear that there was a very real risk that as the perpetrator lacked insight, his condition would relapse, and as a result he could then disengage from services. There was a risk of harm to the victim as a result of the perpetrator's continuing refusal to take medication and historical record of violent actions towards his father when ill. Therefore, admission to hospital may have been warranted notwithstanding the perpetrator's lack of consent.
- 7.27** Using this analysis, the Independent Investigation Team's view is that an attack upon the victim could potentially have been predicted when the perpetrator refused his depot injection on the third occasion on 17 August 2011, by which point, having recognised a problem, Care Co-ordinator 1 should have taken steps to convene a meeting with the perpetrator's parents

and Community Consultant 1 present in order to review his presentation at that time and develop a crisis plan which took the views of the perpetrator's family into account. Such a review had not taken place despite it having been a part of the discharge plan following the perpetrator's discharge from hospital on 25 May 2011. This would also have allowed clinicians to consider when and how powers under the Mental Health Act 1983 could potentially be exercised in a planned manner, which recognised the need for the least restrictive option for the perpetrator, but which also recognised the issues which a relapse of the perpetrator's illness created for those around him, most importantly his father. Potentially these actions could have prevented the attack on 12 September 2011 that led to the victim's death.

- 7.28** Given the pattern of the perpetrator's illness following him ceasing to take medication together with the fact that a significant part of that pattern was expressions of violence or actual violence against his father, once medication had been recommenced the threats of violence ceased, the attack by the perpetrator upon his father on 11 September 2011 was both predictable and preventable from 17 August 2011, had clinicians taken note of the historical pattern of violence as a result of relapse.

Comment Box 1

The Independent Investigation Team's view is that it was predictable that the perpetrator would have committed the homicide of his father.

A Forensic Report dated 21 December 1995 noted that:

'...with adequate levels of medication he is able to stay well for long periods. It is therefore important to ensure that once in the community his progress is adequately supervised and it is ensured that he takes his medication'.

It also states that when the perpetrator is psychotic:

'...he obviously presents a significant danger of violence especially to members of his family'.

Given the pattern of the perpetrator's illness, his response to medication and the fact that the threats of violence which he made to his father formed part of his illness rather than being due to family dysfunctionality, the death of the victim was predictable and preventable from 17 August 2011 which is when he ceased taking medication and reasonable attempts to seek his re-engagement had failed.

8 KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST

- 8.1** Kent and Medway NHS and Social Care Partnership Trust provides mental health and social care services for Kent in partnership with Kent County Council. In Medway, the Trust works closely with the local unitary authority to provide joined-up health and social care services. In 2014, the Trust cared for nearly 50,000 people, involving more than half a million contacts.
- 8.2** The Care Quality Commission (the CQC) monitors, inspects and regulates healthcare services to make sure they meet fundamental standards of quality and safety.
- 8.3** The CQC has published a ranking of NHS mental health trusts according to risk as part of its method of deciding which Trusts to inspect first. As part of the CQC's 'intelligent monitoring' tool, rankings are determined through analysis of 59 different sources of evidence, ranging from concerns raised by healthcare staff, bed occupancy rates, to staff and patient surveys.
- 8.4** Following analysis, Trusts have been placed into bands from one to four, going from highest perceived risk to lowest perceived risk.
- 8.5** Kent and Medway NHS and Social Care Partnership Trust have been rated as 'Requires Improvement'.
- 8.6** Littlebrook Hospital, which is a part of the Trust, provides acute and psychiatric intensive care inpatient services for adults with mental health problems and comprises three wards including a Psychiatric Intensive Care Unit (PICU).
- 8.7** Littlebrook Hospital was inspected by the CQC on 9 October 2013. The Hospital met all of the CQC's standards at this time.

9 JUNCTIONS

9.0 The perpetrator has an established diagnosis of schizophrenia.

9.1 One in a hundred people will suffer from schizophrenia during their lifetime. In addition, it is the 7th most important disease in terms of years lived with a disability, accounting for 2.8% of disability caused by all disease. For people aged 15 to 44 years, it is the 3rd most important disease, accounting for 4.9% of disability caused by all diseases (World Health Organisation (WHO), 2008).

9.2 There is evidence that most people recover, although some will have persisting difficulties or remain vulnerable to future episodes. For every five people who develop schizophrenia:

- 1 in 5 will get better within five years of their first episode of schizophrenia.
- 3 in 5 will get better, but will still have some symptoms. They will have times when their symptoms get worse.
- 1 in 5 will continue to have troublesome symptoms.

9.3 Recovery from schizophrenia is a lifelong process. Successful treatment for schizophrenia aims to relieve symptoms, prevent future psychotic episodes, and restore the individual's ability to function and enjoy a meaningful life. A treatment plan that combines medication with supportive services and therapy is the most effective approach. A significant part of the treatment plan is risk management both of the risk to the individual himself and the risk which the patient poses to others.

9.4 The Independent Investigation Team were asked to construct a timeline of the perpetrator's care from 2 March 2011 to 11 September 2011. This timeline can be found at Appendix C "Chronology".

9.5 The Independent Investigation Team used that timeline and the elements of the CPA to identify a number of 'junctions' or transitions where the perpetrator's care could potentially have taken a different path had clinicians made different decisions.

10 JUNCTION ONE – ABSENCE OF LONG-TERM CARE

- 10.1** The NHS is structured to allow individuals with complex health issues to be managed across multiple services throughout entire episodes of care. The involvement of multiple teams in the provision of mental health care has increased greatly in recent years with the development of functional teams (e.g. home treatment teams, acute inpatient care teams and different types of community mental health teams) that focus on a particular part of the patient's care and treatment. Whilst this has led to advantages, for example it allows a greater number of patients to receive the appropriate level of specialised care to meet their needs, there is a danger that it can lead to a loss of a long-term perspective in care delivery, with each team concentrating on the particular function of that part of the service, and not considering the overall course of care over the endurance of the patient's illness.
- 10.2** In order to support and facilitate long-term care and in response to criticisms raised in the Ritchie Report, the Care Programme Approach (CPA) was introduced. It was introduced to provide a framework for the delivery of effective mental health care partly in response to the Ritchie Inquiry. Its four main elements are:
- Systematic arrangements for assessing the health and social 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 key worker to keep in close touch with the service user and to monitor and co-ordinate care; and
 - Regular review and, where necessary, agree changes to the care plan.
- 10.3** The victim was being cared for under the CPA, as is common for individuals with a diagnosis of schizophrenia. For many patients with schizophrenia, the disorder shows a tendency towards recurrence. Although some patients experience only one acute episode and show few enduring deficits, for many including the perpetrator, the reality is one of recurrent acute symptoms and persisting deficits in their relationships and quality of life.
- 10.4** Patients look at care differently to providers. Patients see care in terms of 'my care', rather than as a series of separate encounters. Care is organised around one or more health concerns that leads to intervention. The point of treatment is to meet specific goals of care. The episode may extend across multiple sites with multiple providers, but for every patient it has a start, middle, and end and is directed towards specific goals.
- 10.5** Whilst acute episodes may often prove relatively straightforward to treat, the practical difficulties involved in establishing the patient on a satisfactory longer-term treatment are more substantial, particularly if the patient lacks insight. A major difficulty is that many patients remain dissatisfied with their treatment; in turn, this contributes to the high rates of non-compliance and of relapse.
- 10.6** The Independent Investigation Team reached the view that a significant feature of the perpetrator's care was a failure to take a long-term view of his

condition during the period 2 March 2011 and 12 September 2011. His care appears to have been delivered as a response to individual acute episodes rather than a desire to achieve treatment goals which would improve the perpetrator's quality of life whilst he coped with a chronic illness. This could also have had an impact upon his compliance with his care and treatment and failure to understand the risk which he posed to himself and others.

- 10.7** The Independent Investigation Team are of the view that the strategy for managing the perpetrator did not take into account the fact that there had been an escalating number of admissions from October 2010 and that non-compliance with medication on discharge would be a probability. There is no evidence in the perpetrator's records of the development of a contingency plan or strategy for managing this likely event. It is noted that no members of the family were at the discharge CPA meeting on 23 March 2011, and the perpetrator's mother had been in telephone contact in the days before this meeting expressing her unhappiness at the plan and stating her view that the perpetrator was too unwell for discharge; that she could not cope with anymore home leave. There is no record that her opinion, which was expressed in this phone call, was discussed at the discharge CPA meeting.
- 10.8** A more detailed examination of the incident with the knife, which should have included an account of the event from the victim, may have helped staff avoid coming to the erroneous conclusion that the perpetrator's problems were 'behavioural in nature' (discharge CPA meeting of 23 March 2011). It should also have prompted a review of the case from the perpetrator's initial presentation. If this had been done, the forensic report from 1995 would have been unearthed, allowing for a more comprehensive evaluation of the risk currently posed by the perpetrator.
- 10.9** The discharge CPA meeting formulated an immediate discharge plan, but it is the failure to look back at how the perpetrator had presented over the course of his illness that led to an underestimation of the current risk posed by the perpetrator. In the opinion of the Independent Investigation Team this constitutes a failure to take a long-term view of the perpetrator's condition.
- 10.10** Contained within the perpetrator's medical records is a large volume of documentation generated by the CPA process which is intended to ensure that the essential aspects of CPA are included in his care. The Independent Investigation Team readily acknowledges that a substantial amount of time and resources has been applied to comply with Trust protocols surrounding completion of these documents. However, rather than representing a vehicle for promoting the perpetrator's care and delivering him with a plan and care package designed to meet his individual needs at each stage in that tailored care, the documentation appears only to deliver plans which are process derived and driven rather than focussed upon the perpetrator's specific needs.
- 10.11** For example, a CPA Care Plan dated 25 May 2011 states that the perpetrator's condition was:

'[the perpetrator] is recovering from a relapse in his mental illness and is now ell (sic) enough to be discharged home'.

10.12 The outcome sought for this was:

'For [the perpetrator] to remain mentally well in the community, have a reasonable sleep pattern, be free of distressing thoughts/experiences and be able to maintain his and others safety'.

10.13 In order to achieve this, the following actions were to be taken:

- 1. [Care co-ordinator 1] to monitor mental state via regular home visits*
- 2. Medication to be reviewed in CPA and Care Reviews*
- 3. Depot injection to be administered as prescribed*
- 4. [the perpetrator] to contact [care co-ordinator 1] if he feels his health is deteriorating*
- 5. [the perpetrator] to abstain from excessive caffeine/nicotine which will inhibit sleep*
- 6. [Care-coordinator 1] and [the perpetrator] to discuss structure to day post discharge from Littlebrook and [care-coordinator 1] will liaise with other agencies/ professionals as appropriate'.*

10.14 This care plan was developed following three admissions to hospital immediately prior to which the perpetrator had refused his medication, had disengaged with services and had become aggressive and threatening to his father. Given that the perpetrator was considered well enough to be discharged from hospital, there was an opportunity to consider with him what his goals for care were and start work to help build compliance with treatment and medication. This did not happen neither in an inpatient nor out-patient setting. Also, the care plan did not put into place any type of crisis or contingency planning, for actions to be taken in the event of the perpetrator stopping his medication or showing signs of relapse. This constitutes a failure to adhere to the key elements of the CPA despite 'procedural' compliance being in place. The result was a failure to deliver patient centred care as care was not built around the perpetrator's individual needs.

10.15 Further, NICE clinical guideline 82 Schizophrenia (issued March 2009) makes it clear that cognitive behavioural therapy (CBT) and family intervention should be offered to individuals with schizophrenia. Counselling and supportive psychotherapy (as specific interventions) can also be offered although not routinely as service user preferences must be taken into account. The perpetrator's notes in relation to this period do not include any indication as to why these options were not made available to the perpetrator.

10.16 It would have been encouraging therefore to have seen as part of the actions to be taken a plan to explore the relationship between the perpetrator and his father in a protected and non-judgemental environment as a means to understanding the perpetrator's illness better in order to generate actions which could help him achieve targeted treatment goals. In addition, a mechanism for helping the perpetrator build strategies for compliance with his medication regime could have also been advantageous.

10.17 In this way the CPA process of care planning could have been used as a vehicle to promote patient focussed long-term care. However, this did not occur on this occasion nor indeed throughout the period considered by the Independent Investigation Team. Paradoxically, the CPA process itself appears to have created barriers towards achieving that aim. For example, in relation to medication in this care plan, it is suggested that this aspect of the perpetrator's care would be reviewed as a part of another process, rather than actively being addressed as part of a timely systematic review.

Comment Box 2

Junction 1: Failure to consider the perpetrator's care from a long-term perspective.

The NHS is structured to allow individuals with complex health issues to be managed across multiple services throughout entire episodes of care. This has significant benefits. However, there is a danger that it can lead to a loss of a long-term perspective in care delivery, with each team concentrating on the particular function of that part of the service, and not considering the overall course over time of the patient's illness.

The Independent Investigation Team reached the view that a significant feature of the perpetrator's care was a failure to take a long-term view of his condition during the period between 2 March 2011 and 12 September 2011. His care appears to have been delivered as a response to individual acute episodes rather than a desire to achieve treatment goals which would improve the perpetrator's quality of life whilst he coped with a chronic illness. This could also have had an adverse impact upon his compliance with his care and treatment and the failure to understand the risk which he posed to himself and others.

Recommendation 1 - Improving Long-Term Care

The Independent Investigation Team wish to make a recommendation to address this general issue and to suggest a potential for assuring subsequent recommendations are implemented in a way that results in the change in practice required to improve patient care viewed from a long-term perspective.

The full implementation of this recommendation will require a cultural shift that cannot be achieved in a single manoeuvre, and which is likely to require a phased plan with a clear programme for implementation and which is regularly reviewed at a senior level within the Trust.

However, until this can be achieved, by focussing upon the delivery of improved long-term care in clinical reviews or transfers of care during clinical supervision (both individual and team supervision) progress towards cultural change can be made.

Recommendation 1

It is recommended that:

1. The Trust further develops its supervision policies and procedures to facilitate supervision being used to promote the delivery of patient centred long-term care.

2. The supervision process should include scrutiny of current samples of actual care delivery at every level to ensure clinical practice reflects the delivery of patient care viewed from a long-term perspective.

3. Regular audits take place to demonstrate that the supervision chain is identifying and addressing any deficiencies in the quality of care being delivered to patients.

11 JUNCTION TWO – FAILURE TO CONSIDER THE FAMILY DYNAMICS IN A NON JUDGEMENTAL FASHION

- 11.1** Living with an individual who has a severe mental illness can be challenging.
- 11.2** Following initial diagnosis, families may be ill-prepared to cope, knowing little about what to expect, except or ideas based on unhelpful and stigmatising stereotypes. They have to learn as they attempt to deal with a variety of services in order to navigate the various pathways which can provide their loved one with the help and care they need. However, this can be a difficult and at times frustrating process. The challenges can prove overwhelming and can be difficult for a family to cope with.
- 11.3** It is of fundamental importance, therefore, that the professionals who deal with the families of individuals with chronic mental health issues demonstrate a genuine understanding of what it is like to live with a severe mental illness, and try to connect with this experience when carrying out their duties.
- 11.4** The reason for this is not simply to prevent families being seen as a problem but instead to ensure that the opportunity which they represent for clinicians as a resource, and means of significant knowledge in relation to the individual who is ill, can be exploited.
- 11.5** In this case, the perpetrator's family were part of the solution to understanding aspects of the perpetrator's presentation. There was a direct correlation between family disharmony and the perpetrator's mental health. There is no evidence in the perpetrator's medical records to suggest that he acted aggressively or violently towards his father, except when he was ill. This was brought to the attention of clinicians repeatedly by his family. However, instead of this issue being explored sensitively and systematically, judgements were made, often without any secure foundation, which may have been unhelpful in relation to the perpetrator's care and treatment.
- 11.6** What is striking for the Independent Investigation Team is that by 2007, the perpetrator's medical records reveal two very different 'explanations' for the family difficulties which were being experienced by the perpetrator's family. The first explanation was suggestive of the fact that when the perpetrator was ill he experienced delusions, some of which had involved his father.
- 11.7** The second explanation was that the perpetrator's parents were exploitative of their son and that the victim in particular was a heavy drinker, and that family issues rather than the perpetrator's illness itself were the cause of many of the difficulties which the perpetrator was experiencing.
- 11.8** For example, during his fourth admission to hospital between 24 March 1992 and 14 April 1992 his records make the following reference:

'He also expressed fear of his own father. The night before admission, things came to a head when the patient made an unprovoked attack on his father and beat him up, after which he spent the night in his sisters [sic] house. The patient said that he believed that his father might be count Dracula, the reason for this

suspicion being that his father prefers red meat cooked rather rare. He believed that his father would harm or kill him and also felt that people might be able to read his thoughts as he thought them’.

11.9 In October 1995, the perpetrator repeated the idea that his father might be Dracula. A forensic report prepared in December 1995 stated:

‘He developed the idea that his father was Count Dracula and was experiencing visual hallucinations of his father coming through the wall. He heard voices telling him to stab his father and that he picked up a very large carving knife from the kitchen and came up to his father from behind. His mother saw this and told him to put the knife down, which he did’.

11.10 An entry dated 19 June 2000, included in his records states:

‘When I visited on 15 June, the seventh week after his last injection, I found all his father’s clothes at the front door and when I asked what was happening, [the perpetrator] said he was throwing his father out. In discussing this further with him, he believed his father to be inside him and that this happened on a number of occasions in the past.

.....[The victim] informed me that that morning [the perpetrator] had been brandishing a carving knife whilst he was sitting on the sofa in the living room and that he himself had left quickly by the back door rather than being in the same room as [the perpetrator]’.

11.11 A further entry dated 26 June 2000 also states:

‘.....When she asked him [sic the perpetrator] about the knife that morning, he stated he wanted to frighten his father. He said that his father pretended to be a lion and was often inside him’.

11.12 During the course of a consultation in September 2006, it was noted:

‘[the perpetrator] has been putting on weight and has been having some disturbing thoughts. He has been thinking he has a womb and is pregnant and that he can feel two heartbeats. During our conversation, he was willing to accept that he is not pregnant and it seems as if this is an overvalued idea. He denies any other experiences of auditory or visual hallucinations’.

11.13 It was further recorded that:

‘[the perpetrator] was reviewed by the Crisis Team on 31 May 2007 where he presented as agitated and expressed anger complying with his medication. His parents reported that he had been verbally abusive, although when he had seen by (...) during the day he had been pleasant in manner....’

‘He denied any unusual experiences such as auditory or visual hallucinations’.

11.14 Later that year during the perpetrator's admission to hospital in the period between 11 August 2007 and 20 September 2007, it was noted that the perpetrator:

'had also previously been physically aggressive towards his father who he had pushed and had made threats against with a knife after feeling paranoid about his parents being against him and whispering about him'.

11.15 However, crucially, notes made during that admission also include the following reference:

'There were issues regarding Adult Protection There were concerns that [the perpetrator's] parents who live with [the perpetrator] in his own house, may have a financial interest in his property and at one point had asked the social workers to declare him insane so that they could take this over. [the perpetrator] has himself expressed a wish to live apart from his parents, which he has not done previously and it seems there is quite a lot of high expressed emotion in the family dynamics. His mother seems to be quite a domineering character and his father drinks heavily on a regular basis. The tension within the home seems to be a recurrent factor in [the perpetrator's] large number of admissions over the years'.

11.16 During a ward round on 29 August 2007, it was agreed that a referral should be made for the family to receive therapy.

11.17 Research has consistently shown that when people who have been given a diagnosis of schizophrenia have family therapy with their relatives, they are less likely to relapse and less likely to be admitted to hospital. Family therapy (also called family work or family intervention) is about helping family members support someone who has a mental illness in the best way, and helping relatives and members of the extended family look after themselves emotionally. It can help family members deal with some of the problems that can result from living with or supporting someone who has experienced psychosis in a non-confrontational or judgmental setting, and it can give relatives the skills to work more collaboratively with health professionals.

11.18 Research has revealed an important role the family can play in helping in the recovery of a person with psychotic experiences. In particular, the attitude of relatives towards the person, and how they understand and react to the person's experiences are very important.

11.19 Families can also influence the extent to which the person is able to recover. Of particular relevance to schizophrenia is the level of 'expressed emotion' (yelling, shouting, fighting, or critical or hostile comments) and stress that is in the living environment of the person with schizophrenia. Research has demonstrated that individuals from families with high 'expressed emotion' are more likely to relapse than individuals from low 'expressed emotion' families.

- 11.20** There are two important aspects to this. The first is that friends and relatives may find dealing with some of the problems that can be associated with psychotic experiences frustrating and difficult, and therefore require support. The second reaction is that families may find the problems experienced by their loved one to be very upsetting, and therefore they try to look after the person intensively. This also creates difficulties for the carer and the cared for individual. Despite being referred to repeatedly in the perpetrator's records, there is no exploration at any stage of the expressed emotion which had been identified with members of the perpetrator's family and, in particular, the victim. However, what is clear from a detailed consideration of the perpetrator's notes is that after September 2007, the focus for consideration of the possible cause for disharmony in the relationships within the perpetrator's family moved significantly.
- 11.21** Collateral histories are sometimes used to obtain information from carers at key points in a patient's care in order to give clinicians an opportunity to formulate an accurate assessment of the individual's problems. There are no indications that anything other than a brief attempt was made to obtain the views of the perpetrator's carers concerning his condition, which highlights some of the issues which can arise as a result of a failure to take a collateral history. If the perpetrator's carers' views had been obtained, then there would have been more input upon the reasons why he might have been relapsing and the risks he might have presented as a result. In addition to obtaining this practical information, a robust consultation of this nature would have also gone further towards ensuring that the family felt that they had a significant input into the perpetrator's care, and that they had had a chance to articulate the strain which they were under and receive appropriate offers of support.
- 11.22** Previously, clinicians were exploring whether the perpetrator's hostility towards his father could arise from the delusions which were a part of his illness. However, following his admission to hospital on 11 August 2007, those responsible for the perpetrator's care appeared to take the view that in fact the perpetrator's parents were exploitative of their son which in turn had an impact upon his illness. This arose from the fact that the perpetrator owned the family home and was based upon information which he provided to services at points when he was very ill and was concerned that he might be pregnant.
- 11.23** What is remarkable in relation to this transition is that it did not occur as part of a systemic review of the perpetrator's notes or following conversations with members of the perpetrator's family. Nor was it based upon information which came to light as part of any formal process which was designed to protect vulnerable adults such as the perpetrator or, indeed, his elderly parents. In fact, whilst a Vulnerable Adult Safeguarding meeting was suggested in September 2007 to consider the allegations raised by the perpetrator about his parents' desire to regain the family home and the fact that his father had been drinking heavily, this was not followed through formally using a recognised process.
- 11.24** An Adult Protection Alert was generated on 27 September 2009. However, it did not produce any action points or outcome measures. In addition, when

new information which could have cast doubt upon the 'exploitation' theory was received, the information was not used as an opportunity for review or reflection. Information, such as the fact that the perpetrator's family were in fact paying the mortgage in respect of the family home or that they had moved out of the family home, was simply disregarded. Crucially, their views were not sought despite the fact that they lived with the perpetrator and were supportive of him at this time and indeed throughout his illness.

11.25 The impact of this change in focus, in the view of the Independent Investigation Team, cannot be underestimated. This change in emphasis as to the explanation for the perpetrator's aggression towards his father led to subsequent underestimation of the level of risk posed by the perpetrator during periods of relapse, which is particularly evident during the admission of March 2011.

11.26 The allegations made by the perpetrator were never the subject of formal review. However, they were accepted at face value and as a possible explanation for his mental health problems, and this appears to have impacted adversely upon how members of the perpetrator's family were heard and, indeed, regarded going forward. Given that they held vital information about the perpetrator and, indeed, the relationship between the perpetrator and his father, this was very disappointing as it appeared to 'taint' the information which they provided to services. The information could have held important information which was relevant to his ongoing care and potentially about how the threat which he posed to himself and his father could have been managed. It could also have provided information which would have allowed a greater degree of support for the perpetrator and his parents as they coped with his chronic illness.

- 11.27** For example, following an attack on his father, a MDT Review Meeting was held on 10 March 2011. The perpetrator was asked about the attack and said 'it was a spur of the moment but he did not intend to harm his father'. There is no detail of the description of what happened in the attack other than the perpetrator's description of his father's conduct. However, the notes of the MDT meeting do, in fact, contain significant detail concerning the ownership of the family home and its outstanding mortgage. It was concluded that there were 'no issues of risk to self or others at this time'. This view was reached without a full understanding of the incident. Of particular concern is that there does not appear to have been any attempt to obtain the victim's account of this incident. Not obtaining the victim's account of the event was a significant failure which led to the risk associated with the perpetrator's relapses being underestimated.
- 11.28** In fact, the knife which the perpetrator used on this occasion was a knife which he had used in respect of all his attacks upon his father and, indeed used, in relation to the fatal attack on 12 September 2011. The perpetrator referred to this knife as a 'vampire knife'. This piece of information could have been useful diagnostically. However, this information did not come to light.
- 11.29** Included in the plan which was constructed following the MDT meeting was an indication that family work would be beneficial. Family therapy is a psychological intervention referred to in NICE Clinical Guideline 1 Schizophrenia March 2009. It could have been used in a number of ways to explore the issues which the family were experiencing. It could also have clarified the issues surrounding ownership of the family home. However, despite several references to the need for family therapy, no such referral was made.

Comment Box 3

It is of fundamental importance that the professionals who deal with the families of individuals with chronic mental health issues demonstrate a genuine understanding of what it is like to live with a severe mental illness, and try to connect with this experience when carrying out their duties.

The reason for this is not simply to prevent families being seen as a problem, but instead to ensure that the opportunity which they represent for clinicians as a resource and expert knowledge of an individual who is ill can be exploited.

In failing to review the complaints about disharmony in the perpetrator's family systematically, rather than judgementally, clinicians missed a significant opportunity to exploit knowledge which in turn could have been of diagnostic and therapeutic benefit for the perpetrator, his family and services.

The impact of this cannot be underestimated. The change in emphasis as to the cause of the perpetrator's aggression towards his father, from it arising from the perpetrator's illness to the cause of the violence being issues in the family dynamics, led to subsequent underestimation of the level of risk posed by the perpetrator during periods of relapse, which is particularly evident during the admission of March 2011.

Recommendation 2 - Building Relationships with Carers

An essential requirement in the long-term care and treatment of patients is the development of an effective and collaborative relationship with carers.

In the perpetrator's case, his carers were closely involved in his daily life and were attempting to provide information which had crucial clinical and therapeutic implications. However, their voices were not heard and instead unsubstantiated judgements were imposed with the information which they presented being disregarded.

The skills required to obtain information and formulate the patient's problems in an accurate and helpful way includes the ability to work collaboratively with carers to develop partnerships. This requires training but also the need for constant review and development in order to ensure that subjective judgements are not allowed to impact upon clinical information.

Consulting the carers of a patient allows medical professionals to obtain crucial insight from those closest to patients, which can reveal the extent of the illness and more information critical to a risk assessment. Additionally, it would alleviate the strain on carers themselves by ensuring their voices are heard, and that they have access to any support which they might need.

This would also give families a voice and a sense they as carers are being taken seriously.

Recommendation 2

It is recommended that:

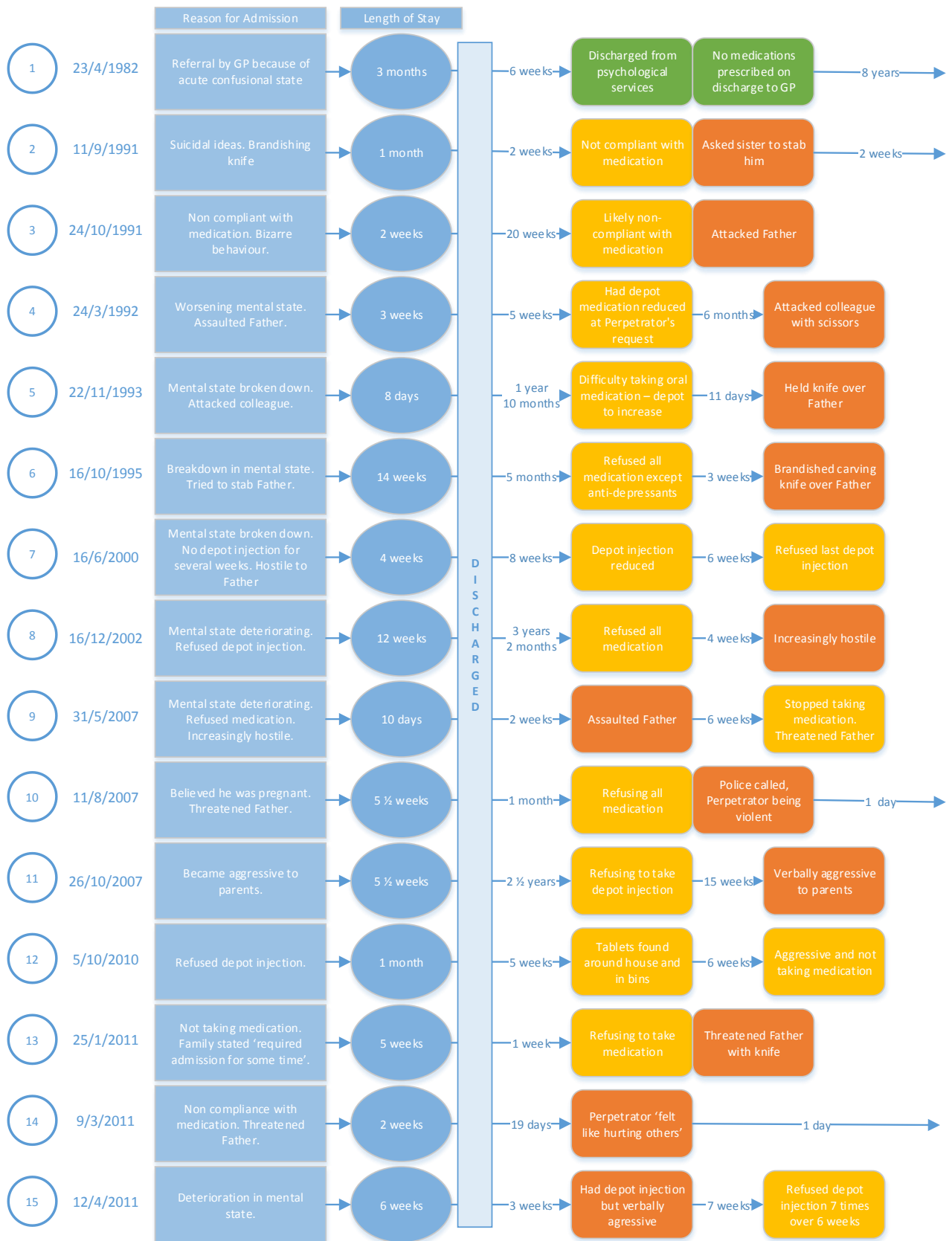
- 1. In order that those treating an individual with a longstanding mental health condition obtain a comprehensive understanding of the current psychiatric, social, family circumstances and risk characteristics of an individual, the Trust's Quality Assurance Programme should be revised to ensure that Teams are required to constantly monitor and review their relationship with individual patient's carers with a view to maximising the value of the information and knowledge which carers can provide.***
- 2. The effective implementation of this recommendation be monitored within the Team Supervision Process as outlined above in Recommendation One.***
- 3. The standard practice of clinical teams in relation to this recommendation is monitored by periodic audit.***
- 4. Collateral histories should be taken from carers to secure a greater insight into a patient's situation and those of the carers themselves.***

12 JUNCTION 3 – GAINING A BETTER UNDERSTANDING OF THE PERPETRATOR’S ILLNESS

- 12.1** The perpetrator first developed schizophrenia in or around April 1982. His illness followed a recurrent pattern through 15 separate admissions to hospital.
- 12.2** Significant features of his illness included his lack of insight, his failure to take his medication leading to relapse and disengagement with services which may have been because either he felt well, or that his illness caused issues with compliance. The violence/aggression which was aimed at family members, particularly his father, was not a feature of the perpetrator’s behaviour when he was well.
- 12.3** However, despite this pattern, little work appears to have been undertaken with the perpetrator to understand and to either minimise his risk of relapse, or indeed make plans for when that relapse occurred during the period between 2 March 2011 and 12 September 2011.
- 12.4** Whilst this might have proved problematic in a crisis situation, work was not undertaken with the perpetrator when he was well to establish a plan to build upon his compliance and improve his quality of life and that of the individuals most closely connected with him. His care essentially evolved around his crisis without any attempt to understand the reasons behind the relapse.
- 12.5** The perpetrator had three admissions to hospital between March 2011 and May 2011. At no stage, whether in an inpatient setting or indeed in the community, was his presentation fully reviewed. The teams responsible for the perpetrator’s care responded to the ‘crisis’ elements of his presentation. However, the response did not address why the crisis arose in order to plan a course of care which was aimed at reducing the risk of a similar crisis in the future. Such a plan could have included information, which would have helped those whose responsibility it was to care for the perpetrator in a crisis situation. It also meant that the opportunity to work with the perpetrator when he was well and potentially more receptive, was lost.
- 12.6** Crucially, the Independent Investigation Team could not find any evidence throughout the perpetrator’s notes nor indeed during the course of the interviews which it conducted that demonstrated any systemic attempt to undertake any work with the perpetrator which was aimed at preventing relapse other than by adjusting the perpetrator’s medication because his care was very much focussed upon individual crisis.
- 12.7** While the prescription of an antipsychotic medication for schizophrenia is the first step of treatment for the resolution of an acute episode of psychosis, comprehensive care requires the integration of adjunctive therapies and attention to long-term treatment goals, including relapse prevention and psychosocial rehabilitation in order to promote recovery. There is very little evidence that this took place either when the perpetrator was an inpatient, or in the community. Recognising that (a) medication was vital in preventing relapse and (b) non-compliance was a recurrent problem, a review that

systematically examined the risks of the case, and formulated a comprehensive multi-disciplinary management plan that would have included psychological and social elements as well as concentrating on medication would have been beneficial.

- 12.8** For example, it was known that the perpetrator was not compliant with his medication and complained of side effects. The response of the clinicians was to adjust his medication. However, a comprehensive review of his medication and an analysis of his complaints was not undertaken in order to establish whether he was experiencing a true side effect of a drug, or if in fact, his complaints were a symptom of his psychosis. If it was the latter, potentially this could have influenced how his care was planned and delivered.
- 12.9** There was a lack of recognition that, following a period of relative stability, including compliance with depot medication between 2007 and 2010, the illness appeared to enter a new and malignant phase from the end of 2010, with a repeated pattern of non-compliance and relapse. When this pattern became apparent, it should have triggered a systematic review of the perpetrator's care. This should have included a review of the historical data, an examination of the management plan to determine if there were alternative approaches to put in place and the development of a contingency plan to provide guidance and advice to family and clinicians, about actions to be taken in the event of signs of relapse becoming evident. If such a review had taken place, those responsible for the Mental Health Act (MHA) assessment in September 2011, would have been in a better position to make an informed decision about the risks posed by the perpetrator.



DISCHARGED



Comment Box 4

The perpetrator's illness followed a recurrent pattern through 15 separate admissions to hospital. Significant features of his illness included his lack of insight and his failure to take his medication leading to relapse and disengagement with services. This may have been because either he felt well or that his illness caused issues with compliance and violence/aggression which was aimed at family members, particularly his father, which was not a feature of the perpetrator's behaviour when he was well.

There was a lack of recognition on the part of those caring for the perpetrator in 2011 that, following a period of relative stability, including compliance with his depot medication between 2007 and 2010, that the perpetrator's illness appeared to enter a new and malignant phase from the end of 2010, with a repeated pattern of non-compliance and relapse.

When this pattern became apparent, it should have triggered a systematic review of the perpetrator's care. This should have included a review of the historical data, an examination of the management plan to determine if there were alternative approaches to put in place, and the development of a contingency plan to provide guidance and advice to family and clinicians, about actions to be taken in the event of signs of relapse becoming evident.

If such a review had taken place, those responsible for the MHA assessment in September 2011, would have been in a better position to make an informed decision about the risks posed by the perpetrator.

13 JUNCTION 4 - UNDERSTANDING THE RISKS WHICH THE PERPETRATOR POSED WHEN ILL

13.1 During his sixth admission to hospital the perpetrator underwent a review by a Forensic Psychiatrist. The perpetrator had been admitted to hospital following an attempt to stab his father on or around 14 October 1995.

13.2 The Independent Investigation Team noted that this Review was comprehensive. It recognised:

1. A link between the perpetrator's failure to comply with his medication and relapse of his condition
2. The risk which a relapse might pose to those around him
3. The manner in which care might best be delivered to the perpetrator.

13.3 Significantly, it included the following observations about the perpetrator's presentation:

'[the perpetrator] is a 32 year old man suffering from paranoid schizophrenia, who has had three worrying- aggressive episodes in the last five years. All three of these episodes seem to be in response to active psychotic symptoms. The present recurrence of his illness appears to be the result of his medication being reduced. [the perpetrator] reports that the second episode when he hit his father also occurred after his medication had been reduced'.

'He is currently well and I believe when well presents little or no risk of violence. When he is psychotic he obviously presents a significant danger of violence especially to members of his family. I agree with your rehabilitation plan in that he is first to go on leave from hospital and everyone involved in his care will be made fully aware of his needs to take medication and the necessity to alert health care professionals should he show early signs of becoming unwell or become non-compliant'.

13.4 The report went on to state that:

'It appears that [the perpetrator's] relapses of psychotic illness are related to a decrease in the amount of medication he takes. There is some question as to whether this is due to him being prescribed less medication or [the perpetrator] feeling that he is well and no longer becoming compliant.As far as I am aware he has suffered no side-effects from his medication and it seems he would be happy with this plan'.

13.5 It is the only occasion which the Independent Review Team identified when the issue of the perpetrator's condition was fully reviewed. It is striking however, that the information in this Review was almost immediately set aside. Indeed within two admissions, its advice was set aside and the perpetrator's care was transferred to his GP.

- 13.6** The perpetrator was admitted to hospital in October 2010 following a period of relative stability in his illness. His previous admission had been between 26 October 2007 and 3 December 2007. He became non-compliant with depot medication in June 2010, and there followed a series of four admissions and two periods of home treatment between October 2010 and May 2011.
- 13.7** On 9 March 2011 the perpetrator was admitted to hospital following an attack upon his father which had required the presence of the Police at the family home.
- 13.8** What is remarkable, is that during the course of these admissions which marked a new phase in the perpetrator's illness, historic data in the form of the perpetrator's paper and earlier digital records was not reviewed to help formulate a treatment plan which was tailored to suit the perpetrator's needs. His medication alone was instead reviewed by Care Co-ordinator 1. This is disappointing as the historical information clearly indicates the high degree of risk presented during relapse. In the absence of the systematic review of this data, his treatment plans and risk assessments were incomplete.
- 13.9** The approach which was in fact adopted failed to take into account the historical pattern of his presentation, in that the perpetrator never fully regained insight and the fact that he was not really prepared to stay on a depot for a prolonged period preferring oral medication which he took with limited success. This should have caused alarm bells to start ringing, leading to a systemic review of this gentleman's history looking for diagnostic clues and information relevant to risk. Had a systemic review been undertaken, then potentially this issue might have been recognised. Instead there was a feeling expressed by the clinicians that the key to caring for the perpetrator lay in getting his medication right. It was believed that in doing this they would be able to obtain the perpetrator's engagement. This view may have been correct. However, in the absence of a systemic review, it was a view that lacked a secure foundation.
- 13.10** The perpetrator's attack on his father on 9 March 2011 was a significant event which warranted police intervention. However, its significance was missed as it was ascribed to being a family dynamics issue, which arose out of tension about the family home. Significant reliance was placed on the fact that charges were not brought by the Police. However, even when the perpetrator's father attempted to speak to the team caring for the perpetrator at this time to discuss the attack, he was not afforded an opportunity to put forward his views. Equally, when his wife and daughter contacted the unit the following day, they too were not heard.
- 13.11** A Local Risk Management Forum for the Recovery Team, which was held on 7 April 2011, discussed the perpetrator's case. The Risk Forum had been established in 2009 to provide for a Multi Professional Clinical Review Forum. Cases were not formally referred to the Risk Forum but were brought by care coordinators or other individuals who obtain new ideas in relation to difficult cases.
- 13.12** The meeting which discussed the perpetrator's care did not include Inpatient Consultant 1. It did not include a review of his paper records. The discussion

focussed once again upon the tension in the perpetrator's family concerning the family review. Despite the family's concerns about the attack on 9 March 2011, the meeting did not include a family representative. The additional risk identified at this time related to ongoing tension in the family dynamics. Its discussions could not be considered to be a systemic review as the review did not consider historic information such as the 1995 Forensic report referred to at Paragraph 13.1 above.

13.13 The failure to conduct a systemic review of the perpetrator's care whilst he was an inpatient was a significant failing and constitutes a junction in his care.

13.14 The failure had an impact not only upon his care at the time but it meant that the results of a review would not have been included in his notes. Had a review taken place which pulled together all of the information in the paper and electronic records, that information would have had a greater chance of coming to the attention of those who saw the perpetrator between 9 and 12 September 2011. The review would have ameliorated the problems with the management of the perpetrator's records.

Comment Box 5

The perpetrator underwent a review by a Forensic Psychiatrist in 1995. This Review was comprehensive. It recognised:

1. A link between the perpetrator's failure to comply with his medication and relapse of his condition.
2. The risk which a relapse might pose to those around him.
3. The manner in which care might best be delivered to the perpetrator.

Repeatedly throughout the course of the perpetrator's care and particularly in relation to the period between 2 March 2011 and 12 September 2011, historic data in the form of the perpetrator's paper and earlier digital records was not systematically reviewed to help formulate a treatment plan or risk assessment which was tailored to suit the perpetrator's needs.

This is disappointing, as the historical information clearly indicated the high degree of risk presented by the perpetrator when experiencing a relapse. In the absence of the systematic review of this data, the treatment plans and risk assessments were incomplete.

This failure had an impact not only upon his care at the time but it meant that the results of such reviews would not have been included in his notes. Had a review taken place which pulled together all of the information in the paper and electronic records, that information would have had a greater chance of coming to the attention of those who saw the perpetrator between 9 and 12 September 2011.

14 JUNCTION 5 - FAILURE TO ADHERE TO THE ETHOS OF THE CARE PROGRAMME APPROACH

14.1 The Care Programme Approach (CPA) is a national framework for mental health services assessment, care planning, review, care co-ordination, and service user and carer involvement focussed on recovery. If used as it was intended: in order to work with service users and carers to build an assessment, establishing care and support needs, it can be a significant asset to the delivery of care. However, the CPA can act as a bureaucratic barrier to care delivery which in turn can lead to its essential elements and purpose being lost.

14.2 The perpetrator's care was the subject of the CPA.

14.3 The perpetrator was discharged from hospital on 2 March 2011. The discharge plan included the following:

- 3. To be followed up by the Crisis Team*
- 4. Longer term follow up by [Care Co-ordinator 1] and Recovery Team*
- 5. Post Discharge CPA to be arranged by [Care Co-ordinator 1]*

14.4 The plan was copied to Community Consultant 1.

14.5 the perpetrator was admitted to hospital once more on 9 March 2011. He remained there between 9 March and 23 March 2011. The discharge plan on this occasion included the following;

- 3. Post Discharge CPA to be arranged by [Care Co-ordinator 1]*

14.6 The plan was copied to Community Consultant 1. A CPA meeting was arranged by Care Co-ordinator 1 on 4 April 2011. Unfortunately this meeting did not occur because Community Consultant 1 was unable to attend.

14.7 The perpetrator was then readmitted on 12 April 2011 due to his deteriorating mental state. He was subsequently discharged on 25 May 2011. A CPA meeting was arranged to take place in the community on 6 June 2011.

14.8 However, this meeting did not take place because the perpetrator and his mother failed to attend. Instead Community Consultant 1 asked Care Co-ordinator 1 to book a further meeting in six months' time or sooner if the Care Co-ordinator had concerns. In the meantime, Community Consultant 1 who had not met the perpetrator and had not performed a systemic review of his case from a historical perspective nor had an opportunity to speak to the perpetrator's carers, increased the dose of the perpetrator's medication due to what she perceived as a significant risk because of the perpetrator's lack of stability at the time.

14.9 A CPA meeting is a formal process in which health care practitioners, members of a psychiatric ward or community team meet with a mental health patient to clarify the care that is to be provided.

- 14.10** Attendees should include the patient, family members, carers and other involved health care professionals. An overview of mental health problems are typically discussed with a core focus on the problem the patient currently faces, their medical problems, financial issues, occupational issues, legal issues, accommodation, support by carers and families, relapse indicators and risk assessment.
- 14.11** The essential function of a CPA meeting is to make a patient feel that his or her needs are fully understood and the proposed care plan adequately addresses all those needs. The meeting ensures that all those involved in the care plan are aware of their individual roles and responsibilities.
- 14.12** A CPA meeting therefore could have led to a number of opportunities for the perpetrator, his clinicians and his carers. However, on a number of occasions throughout his care they have not been given an opportunity to attend. In addition, the purpose of a CPA meeting is to ensure a multi-disciplinary approach. In delegating the opportunity to meet with the family and discuss the care plan to Care Co-ordinator 1, an opportunity for multi-disciplinary working with the family as contributors and resources was lost. In addition, the family's knowledge of the perpetrator's presentation was not hampered by access to records. They could also have been asked for clarification of issues such as the victim's drinking, the problems concerning the house and the context of the perpetrator's acts of aggression towards his father.
- 14.13** In addition, Community Consultant 1's failure to be present at a meeting with the perpetrator and his mother deprived the perpetrator and his carers of an opportunity to discuss or make plans for any future crisis. The perpetrator's illness was a chronic one. The perpetrator's clinicians were keen to secure his compliance with medication. However, the perpetrator's opinions and beliefs about the care he would want in a crisis situation were not discussed. These views could have been given a 'voice' in an advanced care directive. In talking about a crisis situation, the family could also have made its views clear.
- 14.14** There was no evidence of the various components of the service acting together in a coherent way to take an over-arching and long-term view about the perpetrator's care. Although discharge CPA meetings did occur, and 7 day Care Co-ordinator reviews post discharge were arranged, the acute care components of the service including acute inpatients and CMHT, did not appear to work together to develop a comprehensive management plan which would have addressed relapse prevention strategies, a crisis plan, psychological approaches and support for the family. A plan of this nature would have been very helpful when staff were considering the use of the MHA in September 2011.
- 14.15** A further significant example of what appears to be a cultural failure to approach care from a long-term perspective occurred in the period leading up to the attack on the victim.
- 14.16** The perpetrator first refused to take his depot injection on 3 August 2011. Care Co-ordinator 1 explained in interview with the Independent Investigation Team that this was due to side effects. However, Care Co-ordinator 1 did not see any evidence of side effects.

- 14.17** Care Co-ordinator 1 increased the frequency of his visits in response to the perpetrator's failure to accept his medication. He took the perpetrator's medication with him on each occasion which he visited. Visits took place on 3, 10, 17, 24, 31 August 2011. During this period, the Independent Investigation Team was advised that the perpetrator did not exhibit any signs of relapse. However, by 6 September 2011, signs of relapse were becoming apparent. Care Co-ordinator 1 contacted the Crisis Team on 9 September 2011.
- 14.18** The Independent Investigation Team understands that Care Co-ordinator 1 did not speak to Community Consultant 1 during this period. He adopted a 'wait and see' approach which in some respects accords with the least restrictive option and therapeutic optimism. He also increased his home visits in order that a close watch could be kept upon the situation. He then passed the perpetrator's care to the Crisis Team as a crisis had arisen. It is noteworthy however that as a detailed crisis plan had not been prepared as part of a multi-disciplinary process in neither an inpatient or outpatient setting, Care Co-ordinator 1 could not draw upon that to assist him in his decision making processes.
- 14.19** Further, it does not appear that Care Co-ordinator 1 considered convening a CPA meeting, where all the relevant parties could have been brought together and potentially review the historic information which was available in the perpetrator's records in the context of his refusal to take his medication at that time.
- 14.20** At interview, it was clear that Care Co-ordinator 1 had a significant degree of therapeutic optimism that the perpetrator would recommence his medication. However, this level of optimism should have been considered in the context of the perpetrator's historical data.
- 14.21** It is disappointing that neither Community Consultant 1 nor Care Co-ordinator 1 viewed the opportunity of a CPA meeting as being an event which could deliver long-term care and potentially avert a crisis. Even if a crisis could not have been averted, a CPA meeting held on 17 August 2011 could have better informed those who became responsible for the perpetrator's care between 9 and 11 September 2011.

Comment Box 6

There was no evidence of the various components of the acute service acting together in a coherent way to take an over-arching and long-term view about the perpetrator's care.

The acute care components of the service including acute inpatients and CMHT did not appear to work together to develop a comprehensive management plan which would have addressed relapse prevention strategies, crisis planning, psychological approaches and support for the family.

It is disappointing that neither Community Consultant 1 nor Care Co-ordinator 1 viewed the opportunity of a CPA meeting as being an event which could deliver long-term care and potentially avert a crisis. Even if a crisis could not have been averted, a CPA meeting held on 17 August 2011 could have better informed those who became responsible for the perpetrator's care between 9 and 11 September 2011.

Recommendation 3 – Responding to the Patient's needs

A key requirement for the effective care and treatment of patients is the need to systematically review the patient's presentation in order to determine an appropriate response by those involved in the patient's care both in terms of care but also from a risk management point of view. This requirement is supported by the Care Programme Approach.

Such a review should include a review of historical data, examination of the management plan together with an element of contingency/crisis planning which was to apply should a relapse occur.

This did not happen in relation to the perpetrator despite several opportunities being available to do so and as a result, the long-term perspective of the perpetrator's illness was lost and his care became responsive in many respects only to relapse with other issues such as the risk which he posed when he was unwell being unrecognised even when a point of crisis was reached.

The volume of documentation generated by the CPA processes is significant in the perpetrator's care. However, whilst the procedural requirements of the CPA may have been adhered to, the Independent Investigation Team consider that the evidence provided to them indicates that this did not generate an understanding of how the CPA should form the framework under which care can be planned and structured in order to deliver patient centred care.

The Independent Investigation Team wish to make a recommendation to address this issue which in fact forms part of a wider problem within the perpetrator's care which is that the response which the perpetrator received to the care and management of his illness failed to adhere to the ethos of the Care Programme Approach.

The full implementation of this recommendation may require a cultural shift in relation to CPA within the Trust which may not be achievable in a single step. This is likely to require a phased plan, with a clear programme and timetable for implementation which is regularly reviewed at a senior level by the Trust. However, the Independent Investigation Team believe that in order to generate changes in practice which lead to the delivery of care which is tailored towards the needs of patients with a chronic mental health condition, such a cultural shift away from the 'paper' requirements of CPA is necessary.

Recommendation 3

It is recommended that: -

- 1. The Trust should reinforce the position of patient centred clinical care as the cornerstone of care management in delivering services. The essentials of this are contained within the Trust's CPA policy and includes the systemic review and sharing of clinical information to inform clinical decision-making, and the management of risk.***
- 2. The ethos of CPA should be reflected and strengthened in the training programmes staff are required to attend, and the priorities identified in individual and group supervision.***
- 3. Supervision should include routine review of actual cases to ensure the appropriate application of the principles and ethos of CPA have been addressed and to enable corrective action to be taken if required.***
- 4. The implementation of this Recommendation should be monitored by periodic audit.***
- 5. The Trust's Quality Assurance Programme should be revised to ensure that Care Plans reflect a comprehensive understanding of the ethos of CPA in order that current psychiatric, social, family circumstances and risk characteristics of the individual they are treating are addressed and that individual patient centred care can be delivered.***

15 JUNCTION 6 - MEDICAL RECORDS

- 15.1** The perpetrator's medical records span approximately 20 years. They are stored as three formats: paper and two clinical IT systems, ePEX and RiO. In June 2011, the Trust's record system was undergoing a period of migration which meant that some patients' records were in three separate places. Essentially, this meant that it was not a straight forward matter to access all the key information about a patient in any of the three formats.
- 15.2** A key predictor of patient risk is knowledge of their previous history. Accurate patient records are crucial, in order to deliver an appropriate standard of patient care and facilitate assessment of risk.
- 15.3** During the course of the Inquest, the Coroner made the following comments about the perpetrator's records:

'the assessment teams both on the 9th and 12th of September 2011 were not provided with sufficient details of [the perpetrator's] psychiatric history and the previous admissions to hospital. Thus follows the assessment team were not sufficiently aware of his psychiatric history, threats of violence and violence towards [the perpetrator's] father when they carried out the assessment on the 12th September.....'

'It is clear that due to the changes in the recording of psychiatric history the assessment teams were not adequately briefed due to the large amount of the records held without there being an up to date summary of the total of the history available'.

- 15.4** The Independent Investigation Team was concerned about the quality of the perpetrator's records. Aside from the quality of the notes themselves, there were significant difficulties caused by the fact that notes were in three formats spread across a number of years. This caused important information to become lost or difficult to find without significant effort. The system which operated at the time of the perpetrator's care did not allow easy communication of client need, care or risk.
- 15.5** However, it should be noted that the Forensic Report dated 21 December 1995 had been disregarded or indeed lost two admissions later when the perpetrator was discharged into the care of his GP. This indicates a potential cultural issue with regards to records.
- 15.6** The Independent Investigation Team recognise that the perpetrator had several volumes of records going back over many years. However, no attempt was made to complete a case summary based on those records. His entering a new phase of illness from late 2010, and, in particular, the incident with the knife that led to the admission in March 2011, should have been a trigger for a systematic review of all the notes associated with the case. This did not occur, and had a significant impact upon the manner in which the perpetrator's care was delivered.

- 15.7** There were steps that could have been taken by clinicians to reduce the risk of key information not being recognised. This would have involved completing a full review of the perpetrator's notes as part of a CPA review, such as that referred to at Paragraph 12.9. However, this would have been a time consuming task taking at least a half day of professional time, which we were repeatedly told by the Trust that employees did not have.
- 15.8** The issue of access to information contained within patient records is a significant problem across the NHS. The problem is particularly acute in relation to patients such as the perpetrator who may have received care over a number of years and, as a result, have both paper and digital records.
- 15.9** Whilst procedures had been introduced to make care coordinators and/or trainees responsible for ensuring that the new electronic systems used by the Trust is populated with key information from a longstanding patient's files, it was made apparent to the Independent Investigation Team that time pressures may prohibit this transition being fully undertaken.
- 15.10** During the course of the interviews, it became clear that whilst the Trust had taken steps to try and alleviate the risk of information becoming lost, that risk remained in the opinion of the practitioners who were interviewed as part of the Independent Investigation. The issue which was repeatedly mentioned was one of time pressures. In addition, the point was made that as the perpetrator was considered not to have had a forensic history prior to the death of his father, a systemic review of his records would not necessarily happen even today.

15.11 Comment Box 7

The perpetrator's medical records were lengthy. However, had systemic reviews been conducted throughout his care, the risk of important information being absent would have been prevented and this information would have been recorded in the records.

Those providing support and care for family members with a lengthy history of mental illness would have no reason to suspect that medical professionals would not have access to that individual's full medical history as was the case with the perpetrator.

The MDT in place when this incident occurred, who are currently employed within the Trust, are sensitive and aware of the failures in process and communication that played a crucial role in this case. With the passage of time and changes in staff there are fundamental flaws in the migration of patients' medical history that have not been addressed by the Trust. Without the implementation of a strategy for meaningful engagement with carers, there remains the potential for an inaccurate risk assessment in cases similar to this one. For instance, where a patient with an extensive medical history who has been well for a period of time is assigned to a newly appointed consultant, the consultant may be unaware that medical records

must be accessed in multiple formats. This could result in a flawed risk assessment with serious consequences, as have been demonstrated in this case.

Recommendation 4 – Information contained in Medical Records

The Independent Investigation Team have highlighted several areas of concern regarding the identification of risk, the understanding of the perpetrator's presentation, and the management of risk by the teams involved in the perpetrator's care. The perpetrator's notes were voluminous and consisted of paper and electronic records.

A significant factor which lies at the heart of the failure to perform a systematic review of the perpetrator's records is that information in past clinical records was not accessed, utilised and shared with the individuals involved in the later stages of the perpetrator's care. The practical difficulties attached to this task appear to include difficulties in accessing notes in different formats and also time pressures.

In order to obtain a long-term view of a patient, review of information contained in their records is crucial to the delivery of patient centred care and risk assessment. However, the difficulty in doing so is shared by many Trusts throughout the NHS.

In order to address this problem, a strategic response at Board level is required in order to address the practical difficulties which clinicians face when faced with the challenge of accessing a patient's historical records.

Recommendation 4

It is recommended that:-

- 1. Until a strategic response is implemented by the Trust, a protocol is developed to ensure that a review of records across paper and electronic records upon patients who have experienced a number of episodes of care is undertaken at an early stage in relation to a new inpatient admission or CPA review upon discharge or transition from one service to another.***
- 2. The performance of this requirement and adherence to any protocol be monitored and audited.***
- 3. These audits form part of regular Clinical Governance Team Meetings.***

16 JUNCTION 7 - TRUST RESPONSE TO CARER INCLUSION

- 16.1** Throughout the perpetrator's illness it was apparent to members of the Independent Investigation Team that the perpetrator received considerable support from his family, however the inclusion of carers in the care of service users was not part of an embedded culture within the organisation.
- 16.2** Accounts given by the family of the perpetrator's behaviour and its impact upon their lives were treated with suspicion. Statements made by the perpetrator at a time when he was clearly unwell were accepted as fact and no attempt was made by those responsible for the perpetrator's care to establish the true facts of the situation, they were over time accepted as the dynamics that existed within the family.
- 16.3** The victim was persistently denied the opportunity to have his views heard and to express the fear he shared with his daughter that 'they will do something when he kills me'.
- 16.4** There is no evidence that those responsible for the perpetrator's care made any attempt to engage with the victim, who was the perpetrator's next of kin and the focus/target of his son's delusions. This is particularly remiss given that he had been attacked and threatened by the perpetrator on a number of occasions that were recorded, and medical professionals were aware of these incidents.
- 16.5** the perpetrator's family were referred for family therapy, however the appointment was not actioned and as a result they were denied the benefit of counselling. Supporting a relative with a severe mental health problem does not make you an expert; it is an ongoing, exhausting and difficult learning experience. Timely access to a knowledgeable counsellor, who could have provided the family with an opportunity to explore the issues that the family faced in a supportive environment, is the least they could have expected from a system that considered the family dynamics to be a major cause of conflict.
- 16.6** This catastrophic event could have provided a catalyst, driving changes in the organisation's attitude and culture when dealing with carers.
- 16.7** However no significant changes appear to have been made by the Trust and they have not taken the opportunity to take advantage of programmes such as The Triangle of Care. The Triangle of Care approach was developed to improve carer engagement in acute inpatient and home treatment services. The Triangle of Care can be used across all mental health services, not only inpatient settings.
- 16.8** The Triangle of Care guide was launched in July 2010 as a joint piece of work between Carers Trust and the National Mental Health Development Unit, to encourage the need for better local strategic involvement of carers and families in the care planning and treatment of people with mental ill-health.
- 16.9** The guide received further validation when it was included in the Carers Strategy refresh in November 2010 and No Health without Mental Health in February 2011. The Triangle of Care was included as a clear action in Closing

the Gap 2014, the government's mental health action plan. The Triangle of Care has been endorsed by the current government and NHS England as a means of encouraging professionals, service users and carers to work together more effectively and to enable faster and wider carer involvement and support.

16.10 The Triangle of Care initiative requires Trusts to assess and action change in order to identify areas of good carer involvement and those areas that require improvement.

16.11 Kent and Medway NHS & Social Care Partnership Trust are not yet signed up to the Triangle of Care approach. Currently 30 of the 56 Trusts in the UK that provide Mental Health Care are signed up as formal members of the scheme. Kent and Medway Trust do attend the regional groups which are organised by Carers Trust, and meet every six months to share information and best practice. However this involvement is informal and the Trust has not yet committed to being a formal member of the scheme.

16.12 The Independent Investigation Team were advised during the course of the interviews which it conducted that the Trust was experiencing issues in relation to the manner in which it supported carers because of the responsibilities which the Trust itself held and the responsibilities held by the Local Authority. The Independent Investigation Team were advised that:

'The Local Authority has the statutory responsibility for a formal Carers Assessment which in the main is carried out by Social Work Assistants. The Trust (NHS) has a Carers Strategy by which the Trust supports Carers to have a voice and involvement in its matters. The two functions do not operate as an integrated approach towards the holistic needs of Carers and therefore does not consistently involve Carers, where and when appropriate in patient care.'

16.13 This response reflects the problems which patients face in obtaining a long-term approach to their care. Those providing support and care for family members with a lengthy history of mental illness would have no reason to suspect that medical professionals would not have access to that individual's full medical history as was the case with the perpetrator. The patient remains constant, the carers remain constant, but because the organisations change, difficulties arise. It is these difficulties which the Triangle of Care seeks to resolve. This is disappointing.

16.14 Clearly some progress is required to allow families to become a partner in care and to be viewed as a resource which in turn can improve the quality of service provision for patients.

16.15 The Independent Investigation Team is of the view that the Trust needs to make a reappraisal of how they treat families, and to put them at the centre of their thinking and practice. This requires more than the development of a Carers Strategy, and requires changes to the culture exhibited as existing throughout the perpetrator's care.

16.16 The Independent Investigation Team recommends that organisations providing services take steps to demonstrate how they meet the following criteria:

- Every encounter with the service user should prompt a practitioner to think “what about family?” (Despite the fact it will not always be relevant and not everyone wants them involved).
- Families are actively supported in their caring role – not abandoned or judged.
- Family interventions are made available and referrals are followed through.
- Families do not experience unnecessary barriers to information sharing – giving their own views or receiving relevant non-personal information.
- There is respect for, and acknowledgement of, the role of long-term carers.
- There is a named key worker and point of contact to access the system in a crisis.
- Family involvement in training practitioners and reviewing services is the norm.

16.17 The Independent Investigation Team believe there are practical steps which can be taken to help this situation:

- Advance directives should be offered to all people with severe mental illness to help manage treatment preferences when a person becomes unwell.
- Consent to share information should be updated regularly to promote effective communication between practitioner, the person and family members.
- Carers should always be given a contact point to access the mental health system in a crisis.

16.18 In addition, the importance of the Carer Strategy as a vehicle to ensure that carers receive appropriate psychological as well as practical support should be recognised and supported. It is unclear to the Independent Investigation Team whether the current strategy adopted by the Trust provides sufficient focus upon providing support for the mental wellbeing of carers and family members.

16.19 The Independent Investigation Team’s considers that there would be some merit in reviewing the Trust’s Carer’s strategy to ensure that carers receive appropriate psychological as well as practical support. This is important given the current focus upon the practical role which carers play in the approach to carers adopted by the Trust and as a result, there may not be sufficient consideration for the mental wellbeing of family members and carers.

16.20 In conducting such a review, the following should be recognised:

1. Carers and the essential role they play should be identified at first contact or as soon as possible thereafter.

2. Staff are empowered to become 'carer aware' and trained in carer engagement strategies.
3. Policy and practice protocols regarding confidentiality and sharing information, should be in place.
4. Defined post(s) responsible for carers are in place.
5. A carer introduction to the service and staff should be made available, with a relevant range of information across the care pathway including information to support carers wellbeing.
6. A range of carer support services should available including support for carers wellbeing.

Comment Box 8

Throughout the perpetrator's illness it was apparent to members of the Independent Investigation Team that the perpetrator received considerable support from his family, however the inclusion of carers in the care of service users was not part of an embedded culture within the organisation.

Accounts given by the family of the perpetrator concerning his behaviour and its impact upon their lives were treated with suspicion, statements made by the perpetrator at a time when he was clearly unwell were accepted as fact and no attempt was made by those responsible for the perpetrator's care to establish the true facts of the situation, they were over time accepted as the dynamics that existed within the family.

The victim was persistently denied the opportunity to have his views heard and to express the fear he shared with his daughter that 'they will do something when he kills me'.

This response reflects the problems which patients face in obtaining a long-term approach to their care. Those providing support and care for family members with a lengthy history of mental illness would have no reason to suspect that medical professionals would not have access to that individual's full medical history as was the case with the perpetrator. The patient remains constant, the carers remain constant, but because the organisations change, difficulties arise. It is these difficulties which the Triangle of Care seeks to resolve. This is disappointing.

Recommendation 5 - Working With Carers

The Independent Investigation Team has highlighted a number of issues regarding a lack of inclusion of carers' views in the care of the perpetrator.

Recommendation 5

It is recommended that:-

The following practical steps are taken to ensure the inclusion of carers' input into the care provided to patients:

- 1. Advance directives should be offered to all people with severe mental illness to help manage treatment preferences when a person becomes unwell.***
- 2. Consent to share information should be updated regularly to promote effective communication between practitioner, the person and family members. Protocols and policies should be introduced to secure this.***
- 3. Carers should always be given a contact point to access the mental health system in a crisis. Communication should be established as early as possible.***

4. The Trust review its carers strategy to ensure that carers receive appropriate psychological as well as practical support.

17 REACTION TO INCIDENT BY HEALTHCARE PROVIDERS

17.1 As part of its Terms of Reference, the Independent Investigation Team is required to:

‘Review the Internal Investigation Report (SUI 2011/21879) and assess the adequacy of its findings, recommendations and action plan.

Review the progress that has been made in implementing the action plan’.

17.2 The Independent Investigation Team note that the Trust conducted an Internal Investigation concerning the immediate period prior to the death of the victim. Learning for the Trust was achieved from that review which concerned the Trust’s response to the crisis situation in which the perpetrator found himself in September 2011. The Trust also completed a 72 hour report as per its own policy at this point. This was undertaken by a Service Manager. Following this, an Internal Investigation focussed on the statutory intervention, which had been requested at the time of crisis.

17.3 However, the Independent Investigation Team was concerned that a number of the individuals most closely involved in the care of the perpetrator were not involved in the Internal Investigation, and appeared unfamiliar with the resultant Action Plans. Further, the Independent Investigation Team are concerned that the results of the various investigations carried out into this case were not shared or disseminated to these individuals.

17.4 In addition, the Independent Investigation Team are concerned that the Trust did not look more widely in relation to the perpetrator’s care to determine how that crisis could have been avoided or handled differently and concentrated upon the crisis situation which arose between 9 and 11 September 2011, rather than to consider why the crisis arose in the first place.

17.5 The Independent Investigation Team recognise that a degree of investigation fatigue can become a feature of a case which has already been the subject of 3 major investigations. However, the Investigation Team were surprised to hear that view so strongly expressed in interview.

17.6 Further, as the Independent Investigation has sought to demonstrate, there is still considerable learning for the Trust arising out of the perpetrator’s care if a less restrictive view than simply the events of 9 and 11 September 2011 are considered.

Comment Box 9

The Independent Investigation Team note that the Trust conducted an Internal Investigation concerning the immediate period prior to the death of the victim. Learning for the Trust was achieved from that review concerning the Trust’s response to the crisis situation in which the perpetrator found himself in September 2011.

In addition, the Independent Investigation Team are concerned that the Trust did not look more widely in relation to the perpetrator's care to determine how that crisis could have been avoided or handled differently and concentrated upon the crisis situation which arose between 9 and 11 September 2011 rather than to consider why the crisis arose in the first place.

Further, as the Independent Investigation has sought to demonstrate, there is still considerable learning for the Trust arising out of the perpetrator's care if a less restrictive view than simply the events of 9 and 11 September 2011 are considered.

Recommendation 6 - Learning from Adverse Events

The Independent Investigation Team believe that the Trust could have extracted a greater degree of learning from the perpetrator's care if that care had been looked at from a long-term perspective and not simply at the Trust's response to the perpetrator finding himself in a crisis situation on 11 September 2011.

Recommendation 6

It is recommended that:-

1. In order to maximise the learning from significant events such as the perpetrator's fatal attack upon his father, an approach is adopted which seeks to understand the bigger picture rather than adopting a restrictive approach. For example investigating how a crisis has developed as a means to identifying whether there was a greater opportunity for the learning which can generate improvements in service delivery. The Independent Investigation Team recommends that the Trust's Framework for investigating such incidents be reviewed to implement this recommendation.

2. The Trust takes active steps to ensure that staff and clinicians are supported in relation to adverse events.

3. The Trust must implement processes to ensure that the learning from adverse incidents and the action points which are generated are drawn to the attention of staff and clinicians involved in the events in order that learning can be embedded in the day to day practices of those responsible for delivering care.