INDEPENDENT INVESTIGATION REPORT

REFERENCE SUI 2004/1964

TO BE PRESENTED TO THE NHS YORKSHIRE AND THE HUMBER BOARD 1 DECEMBER 2006

This Independent Investigation was commissioned by the South Yorkshire Strategic Health Authority (now part of NHS Yorkshire and the Humber) in keeping with the statutory requirement detailed in the Department of Health guidance titled ñIndependent Investigation of Adverse Events into Mental Health Servicesòissued in June 2005. This requires there to be an independent analysis of the care and services offered to Mental Health Service Users involved in incidents of homicide where they have had contact with the Mental Health Services in the six months prior to the incident and replaces the paragraphs in ñHSG (94)27òwhich previously gave guidance on the conduct of such enquiries.

The Investigation Team Members were:

- Ms Maria Dineen, Director, Consequence UK Ltd.
- Dr Mark Potter, Consultant Psychiatrist, South West London and St Georges Mental Health NHS Trust.
- Mr Dave Sharp, Independent Health and Social Care Consultant and Associate of Consequence UK Ltd.

Acknowledgements:
The Investigation Team wish to thank all of the people they met who gave willingly of their time to assist us in understanding the full picture and context of the care and management of S3, the Service User who is the subject of this report. In particular the Investigation Team wish to thank S3ôs mother for her openness with the Investigation Team and her patience while waiting for this report to be completed.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Intention

This report sets out the Investigation Teamôs findings and recommendations following its analysis of the care and management of Patient S3 (S3) between October 2002 and July 2004. S3 was convicted of murder on the 27th May 2005.

Purpose

The purpose of the investigation was to:

- Determine whether or not the care and management of S3 between October 2002 and July 2004 was appropriate.
- Identify areas for improvement in the delivery of mental health services to persons with Personality Disorder.

Outline of Investigation Process

The investigation was led by Maria Dineen and the core activities undertaken were:

- A comprehensive documentation review.
- The creation of a detailed chronological timeline detailing S3ôs contact with mental health services.
- The identification of what was managed well and what aspects of S3ôs care and management could have been improved.
- Making recommendations where appropriate.

There was no systems analysis undertaken in this investigation as a full systems review of all relevant aspects of mental healthcare provision was undertaken in the investigation of the care and management of two other Service Users involved in homicide incidents in Sheffield between 2003 and 2004.

Main Findings – Strengths in S3's care and management

The Investigation Team found S3ôs care and management by Sheffield Care Trust (SCT) to be of a good standard. There is clear evidence that, despite professionalsôreservations regarding S3ôs willingness to engage with therapeutic opportunities, the mental healthcare professionals made continual efforts to try and engage with her. The Investigation Team therefore has no criticism of Sheffield Care Trust. A breakdown of the positive feedback the Investigation has for the Trust is contained in Section Five of this report.

With regard to S3ôs care and management at the Low Secure Facility provided by Capio Nightingale, a private facility in Liverpool, discussions with the staff and a review of their clinical records also evidenced appropriate care and management of S3.

Main Findings – Issues of concern

There were three concerns identified by the Investigation and these relate to S3's care and management at the low secure facility in Liverpool. These were

- S3 was admitted to the Low Secure Facility in Liverpool on an Interim Hospital Order via Newhall Women's Prison. At the time of her admission the date for her reappearance at Court had been set for the 6th May 2006. When S3 re-attended Court as planned no provision had been made for her possible discharge and there was therefore no care plan in place.
- The report provided to the Court by S3's Consultant Psychiatrist at the Low Secure Facility was not as clear as it could have been regarding his own clinical opinion of S3's diagnosis.
- The clinical records review showed no evidence that consideration had been given to taking S3 off all medications to try and achieve clarity in her diagnosis.

It is important to note that none of these issues had any adverse impact on the subsequent management of S3 by Sheffield Care Trust.

Main Conclusions

As a result of this investigation the conclusions of the Investigation Team are:

- The care and management of S3 was of a good standard.
- The incident that occurred on the 8th July 2004 was not preventable by any of the staff or agencies engaged in her care or supervision in the community. S3 was recognised as a high risk individual by virtue of her past behaviour and her unpredictability. However there was nothing to suggest that she would carry out such a violent attack on another individual. Furthermore the current constraints of the Mental Health Act 1983 would not have enabled the health care professionals to have detained S3 at any time prior to the incident because she did not meet the criteria for this.
- The discharge of S3 from the imposed Interim Hospital Order on the 6th May 2006 was appropriate.
- S3 was an individual who persistently refused to engage in therapies that may have enabled her to manage her life better. The therapies, such as Cognitative Behavioural Therapy, that may have assisted this young woman cannot be enforced, and one has to show a willingness to explore self. S3 never displayed any such willingness.

Recommendations
The Investigation Team has no recommendations to make to SCT with regard to the management of persons with Personality Disorder.

With regard to the Low Secure Facility provided by Capio Nightingale:

1. It must ensure that where clients are admitted directly from the Court or from Prison, and there is an existing mental health history and Community Mental Health Team involvement, that it actively engages with the ôhome care teamô The Investigation Team accepts that this is the usual standard of practice for this facility but it did not occur for S3 because her route of admission was unfamiliar to the service at the time and they did not anticipate her discharge from the Interim Hospital Order even though there would have been no grounds to have maintained this.

2. That the Consultants and Senior Nurses at Capio Nightingale Liverpool consider if a trial of no medication is appropriate where persons are compulsorily admitted for assessment and treatment as a valid process to achieve clarity in diagnosis where Personality Disorder is considered but where uncertainty exists.

3. Given the importance of Psychiatric Assessments prepared for the Courts it is suggested that there are agreed local and/or national guidelines to assist Consultant Psychiatrists in the preparation of these.

INTRODUCTION

On the 8th July 2004 S3 was involved in a disturbance outside a nightclub in Liverpool. During this disturbance she attacked another young woman who subsequently died of her injuries.

S3 had been in contact with mental health services since October 2002. The main precipitators for her contact with the service were acts of self-harm. Following a period of assessment her diagnosis was determined as Borderline Personality Disorder. At no time were there any convincing signs of delusion or psychosis.

The eighteen months of S3's contact with the mental health and probation services was punctuated by:

- A lack of engagement.
- Frequent acts of self-harm.
- A number of arrests by the police.
- A custodial sentence and subsequent compulsory hospital order for assessment.

With respect to S3's forensic history between January to September 2003 this was as follows:

- 1 offence against a person (2003).
- 3 offences against property (2003).
- 1 offence relating to police/courts/prison.
- 1 miscellaneous offence (2003).

S3 received three convictions over this period.

Subsequent to these incidents S3 was arrested for the imprisonment of two health workers on the 21 August 2003. She was detained on remand in Newhall Prison pending her court appearance in January 2004. This resulted in an interim hospital order under Section 38 of the Mental Health Act (1983) and S3's admission to a private low secure facility in Liverpool. S3 was subsequently discharged from the hospital order on the 6th May 2004 and discharged to her Stepfather's address on the 7th May 2005.

Between this time and the date of the incident there was good effort made by her Care Coordinator (CC2) to make, and maintain, contact with her. The final contact was on the 7th July. During this time there were concerns about S3's risk status, and all staff recognised that S3 may offend again and that she continued to pose a risk to herself and others by virtue of her unpredictability. However there was nothing that the mental healthcare professionals could have done that could have averted the events of the 8th July.

Contact with the Family of S3 and the Family of the Victim
Two members of the Investigation Team met with S3ûs mother in May 2005, and subsequent to this telephone contact was maintained.

The Family Liaison Officer for the family of the victim was the communication conduit for the Investigation Team. After some consideration the Victimûs family decided that they would prefer not to meet with us.

Contact with S3
The Investigation Team were not able to have any contact with S3. Approximately four weeks after her conviction for Murder in 2005 she took her own life in prison.

Note: see Appendix 1 for a more detailed chronology of S3ûs contact with the mental health and primary care services in Sheffield.

2.0 TERMS OF REFERENCE

To examine the circumstances surrounding the treatment and care of the Service Users Involved in the homicide events and in particular:

1. To examine:

- The quality and scope of health care, social care and risk assessments.
- The appropriateness and quality of treatment, care, management, supervision and operational policies in respect of:
    i. Assessed health and social care needs
    ii. Assessed risk of potential harm to the patient and others
    iii. Any previous psychiatric history, including drug and alcohol abuse
    iv. The number and nature of any previous court convictions.
- The extent to which the ónamed patientôs care corresponded to statutory obligations; relevant guidance from the Department of Health; local operational policies and best practice.
- The extent to which prescribed care plans were effectively drawn up, delivered and complied with, including where appropriate, in accordance with the care programme approach.

2. To examine the appropriateness of the professional and in-service training of those involved in the care of, or in the provision of services to, the named patient.

3. To examine the adequacy of the working arrangements, collaboration and engagement with, and communication within and between:
    - The agencies involved in the provision of care and services to the patient - including in respect of risk information sharing.
    - The statutory agencies and the patientôs family.

4. To examine such other issues relevant to the specific circumstances of the individual case, e.g. cultural and social issues.

5. To determine what improvement plans have been implemented since the Trustôs Internal Investigations and whether the effectiveness of these interventions has been assessed.

3.0 METHODOLOGY

In this investigation Root Cause Analysis (RCA) principles were applied. The guiding investigative framework followed was that detailed in the National Patient Safety Agency's (NPSA) RCA e-learning tool kit.[1]

The specific investigation and analysis tools utilised were:

- The Consequence UK Ltd structured Timeline
- Investigative Interviewing (cognitative interviewing)
- Thematic Analysis

The primary sources of information used to underpin this review were:

- S3's clinical records.
- Key policies and procedures pertinent to the care and management of S3.
- Interviews with key staff engaged in the care and management of S3.
- A visit to the Low Secure Facility in which S3 was a patient in between March and May 2004.

Note: please see Appendix 2 for a full list of persons interviewed and documents reviewed during this investigation

[1] NPSA e-Learning tool kit August 2004 www.npsa.nhs.uk/ipsel

4.0 PERSONALITY DISORDER

The illnesses, diseases and injuries suffered by individuals who seek and receive care and treatment from doctors are currently recorded using the International Classification of Diseases, Tenth Revision (ICD-10), published by the World Health Organization (WHO).

Information about a person's diagnosis, recorded in their notes by the clinician treating them, is translated into ICD-10 codes by a clinical coder, which means that it is possible to select and compare conditions consistently across the world wherever ICD-10 is used.

The ICD10 description of Personality Disorder is:

'A specific personality disorder is a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality, and nearly always associated with considerable personal and social disruption.'

In relation to Borderline Personality Disorder MIND, a leading mental health charity in England and Wales, provides the following explanation in its fact sheet 'Understanding Personality Disorder'[2]

"BPD is one of many personality disorders listed in the manuals used by clinicians when they are giving someone a psychiatric diagnosis. The word 'personality' refers to the ongoing pattern of thoughts, feelings and behaviour that makes us who we are. A personality disorder may be diagnosed when it's felt that several areas of someone's personality are causing them or others problems in everyday life. This diagnosis is very controversial, because it implies that someone's whole personality is flawed - rather than just one aspect of them. Some psychiatrists argue that it's impossible to treat someone's personality and that it's wrong to apply medical terms and treatments to a personality. This means it's usually the symptoms of BPD that are treated, rather than the disorder as a whole. (See Understanding personality disorders for more information about this particular group of diagnoses.)

Some argue that the term 'borderline' is misleading. Originally, the term was applied to people who seemed to be on the border of being given a diagnosis of schizophrenia. However, now BPD is seen as distinct from schizophrenia diagnoses, the 'borderline' aspect is seen to express being on the border of psychosis. If someone has a psychosis, it means they have beliefs or experiences not shared by others. Those diagnosed with BPD may have these at times of stress.

It's been estimated that three-quarters of those given this diagnosis are women. In the USA, BPD is thought to affect two out of every 100

[2] http://www.mind.org.uk/Information/Booklets/Understanding/Understanding+borderline+personality+disorder.htm

people. Unfortunately, there are no equivalent UK statistics, at present. It's a condition that isn't usually diagnosed until adulthood, because the personality is seen as still developing until then.

Because of the controversy surrounding this diagnosis, services are often not readily available."

5.0 FINDINGS DIRECTLY RELEVANT TO THE CARE AND MANAGEMENT OF S3

S3 had a relatively short period of contact with the mental health service in Sheffield. Therefore the Investigation Team reviewed all of her clinical records.

It is the impression of the Investigation Team that S3 was a troubled young adult frequently self-harmed and who was not willing share her inner most thoughts and feelings with the health and social care professionals who were trying to help her. Although it is clear that S3's problems commenced in her teenage years the causes of these have never been fully understood owing to S3's unwillingness to talk about this and inconsistencies in some of the information she did share.

The efforts made by the healthcare professionals in Sheffield to engage with S3 and to support her with her mental health issues were excellent. Furthermore it appears that the care provided by the Low Secure Facility in Liverpool was also of a good standard.

5.1 POSITIVE FEEDBACK

- The initial risk assessment undertaken by the Deliberate Self Harm (DSH) Team was comprehensive and clearly documented. A strength of this risk assessment was its openness about the difficulties in quantifying the continuing risk for S3 as she had refused to talk about her problems.
- The analysis of S3's clinical records and interviews with staff evidence reasonable efforts on behalf of the mental healthcare team to engage with S3's mother to seek as much background information about S3 and her contemporary circumstance as possible. In the period leading up to S3's admission to the Low Secure Facility in Liverpool, and following her discharge back to Sheffield one continues to see evidence of contact and liaison with S3's mother even though relationships between her and her daughter were strained.
- Between October 2002 and July 2003 both Consultant Psychiatrists who were involved with S3 made clear their expectations regarding her behaviour and the acceptable boundaries to this. Consultant C1 in particular is robust and consistent in her treatment of S3.
- When it became clear that S3 hoarded her medications to fuel her over dose attempts the Mental Health Service advised her GP to stop prescribing medications. Furthermore the GP was advised that there is no clinical reason for S3 to be on Venaflaxine as the sleep and appetite disturbances she reports are more likely to be a bereavement response to the

death of her boyfriend. Subsequent to this there is evidence to show responsible prescribing practice for S3 and appropriate response by her Care Coordinator in 2003 to concerns raised by the GPøs regarding her medication review.

- During S3øs attendances at hospital following Deliberate Self Harm (DSH) attempts the clinical records show that all professionals who came into contact with S3 undertook detailed and careful assessments, including appropriate exploration of the voices and images S3 claimed to see and hear. On no occasion were any signs of psychosis identified. The Investigation Team found no evidence that S3øs assessments were compromised in any way by virtue of her diagnosis of Borderline Personality Disorder.

- The CMHT staff worked hard to try and find appropriate supported accommodation for S3 in 2003 and 2004.

- There is clear evidence of good communications between the mental health professionals in Sheffield with other agencies such as the Supported Housing Projects where S3 was a tenant and the Probation Service. The Court Diversion and Liaison staff were also proactive in their communications with Health and Probation Staff and also with the Commissioners of Secure Services for S3 via the Gate Keeping Service.[3]

- In October 2003 S3øs new Care Coordinator (Care Coordinator 2) made a good effort to try and engage with S3. In-spite of the information provided to him about her history he agreed to support her in obtaining a medical re-examination for Psychosis and seemed to try and communicate to S3 that he was taking her reported experiences of voices and delusions seriously even though the likelihood of her actually experiencing these was unlikely. He also acknowledged to her, her distress. Throughout his contact with S3 this Care Coordinator showed diligence and sensitivity towards S3 responding appropriately to concerns raised by her and others and seeking appropriate advice from colleagues.

- In February 2004 good quality information was provided by the NHS Service to the Low Secure Facility in Liverpool in preparation for her admission there in March from Newhall Womenøs Prison.

- Although there was limited access to psychological therapies at the Low Secure Facility S3øs care plan was reasonable and identified all of the key issues that S3 needed to address. The ward staff were able to evidence good use of one-to-one time

[3] This is a process by which an individualøs need for secure care is assessed and the most appropriate type of secure facility is agreed and provision for funding made.

with S3 and maintained good quality records regarding her progress and behaviour on the ward.

- The system of óweekly updateô reports used at the Low Secure facility was structured and provided a good overview of S3ôs progress and difficulties.

- On the 8th June 2004 Consultant Psychiatrist C1 wrote a very detailed report about S3 that was widely circulated including copies to S3ôs Care Coordinator (CC2), S3ôs GP, S3ôs Probation Officer and the Court Liaison and Diversion Team. . This report made explicit the risks associated with S3, in particular her unpredictable behaviour and her potential risk to others evidenced by this behaviour and the fact that she had held two health workers hostage while in possession of a weapon. Consultant C1 highlights her advice in bold that S3 is not to be seen at home but in a public place with appropriate security. Consultant C1 also states that S3 ñis responsible and there is certainly no evidence from past history of her criminal offences that these were in any way conducted whilst she was either psychotic or in a dissociative state.òConsultant C1 goes on to emphasise this by saying that if S3 commits a serious offence ña custodial sentence should be considered albeit on the hospital wingò. The Investigation Team found the report to be of an excellent standard.

- S3ôs Care Coordinator (CC2) made reasonable efforts to try and secure a female CPN for S3 in keeping with her wishes and the advice of Consultant Psychiatrist 1. Although this was not possible to achieve this professional ensured that he had a female colleague to co-work with him.

- After her discharge from the Interim Hospital Order S3 was placed on Enhanced CPA to ensure that there was access to appropriate services for her if she would engage. Furthermore the CPA process was seen as a way to ensure that continuing good multi-agency communications occurred. It is important to note that the mental health team was quite clear that placing S3 on enhanced CPA was not to result in a reduction in the level of responsibility S3 had to take for herself, including her actions. Neither was it an acknowledgement that she may have a psychotic illness.

- S3ôs Care Coordinator (CC2) undertook a detailed assessment of S3 on the 7th July with a female colleague. The impression of both professionals was as follows:
    - Good engagement in the conversation
    - Not distracted by hallucinations or dissociation

- Sometimes tearful and frustrated ï especially when not wanting to accept Consultant Psychiatrist 2ôs assessment
- No overt anger, no direct aggression and no direct threatening comments or behaviour

5.2 CARE DELIVERY AND SERVICE DELIVERY CONCERNS

The Investigation Team could not identify any aspect of S3ôs care and management by the mental health service in Sheffield that gives cause for concern. There were however three issues of potential concern that the Investigation Team identified arising from S3ôs period of care provided by a private facility in Liverpool between March to May 2004. It is important to note however that none of these affected the management of S3 by the clinicanôs in Liverpool, the clinicanôs in Sheffield or the decision made by the Court to discharge S3 back to the community in May 2004.

These issues were:

- S3 was admitted to the Low Secure Facility in Liverpool on an Interim Hospital Order via Newhall Womenôs Prison. At the time of her admission the date for her reappearance at Court had been set for the 6th May 2006. When S3 re-attended Court as planned no provision had been made for her possible discharge and there was therefore no care plan in place.
- The report provided to the Court by S3ôs Consultant Psychiatrist at the Low Secure Facility was not as clear as it could have been regarding his own clinical opinion of S3ôs diagnosis.
- The clinical records review showed no evidence that consideration had been given to taking S3 off all medications to try and achieve clarity in her diagnosis.

Following the Investigation Teamôs interviews with staff in Liverpool namely S3ôs Consultant Psychiatrist, the Clinical Services Manager and S3ôs named nurse the Investigation Team understand that:

The Lack of Preparedness for S3's discharge

At the time S3 was a patient in Liverpool the Low Secure Facility did not have any experience of admitting patients under Section 38 of the Mental Health Act or directly from prison. Most of their admissions were on an individual private basis and to cover the shortfall in low secure beds available within the NHS. The named nurse for S3 in Liverpool remains adamant that they did not expect her to be discharged from the interim hospital order on the day of her attendance at court on the 6th May 2004 and had therefore made no provision for this. The Investigation Team gained the impression that this individual remained surprised that she was discharged. S3ôs

Consultant Psychiatrist at the time advised that when the Interim Hospital Order was revoked they had ónó power to hold herô She was not ósectionableô However had she been willing to remain as an in-patient then she would have been offered a bed. In this Consultantôs opinion S3 would not have been amenable to accepting a further in-patient stay in Liverpool or at any other mental health facility.

Had the ward staff at the Low Secure Facility referred to the Mental Health Act they would have been aware that an interim hospital order can be in force for a period not exceeding 12 weeks. This period can be extended for further periods not exceeding 28 days at a time if it appears to the Court on the written or oral evidence of the responsible medical officer that the continuation of the order is warranted.

The report provided to the Court by the Consultant Psychiatrist responsible for her care and management in Liverpool states

ñAs regards treatment for her personality disorder I do not think her personality disorder is of a severity which warrants treatment in a secure unit. She has generally been settled and I think in this environment she is at risk of learning maladaptive behaviours from other patients who are more severely affected. I think ideally she would benefit from a community group home with a large degree of social and occupational support with appropriate boundaries in place. I anticipate difficulties in finding this type of placement and an alternative would be normal accommodation in the community with a package of support from psychiatric and social services.ò

On the basis of the impressions of her Consultant and the information shared by the care team in Liverpool at the weekly ward round it was foreseeable that S3 would be discharged from her interim hospital order and therefore could no longer been detained at the hospital against her will. S3ôs Consultant Psychiatrist at the time accepts that he and the ward staff could have been more forward thinking with respect to the discharge planning process for S3.

The lack of clarity and clear diagnosis in the report provided to the Court on the 6th May 2006

When the Investigation Team read the report submitted by S3's Consultant Psychiatrist in Liverpool we did not feel that the findings of his assessment of her was presented with the degree of clarity one would expect for a Court Report and it lacked depth with regard to the treatment and assessment provided to S3 while she was in Liverpool.

During the Investigation Team's interviews with staff in Sheffield, in particular

- S3's Consultant Psychiatrist C1
- The Court Diversion and Liaison Nurses
- S3's Care Coordinator in May 2004

and S3's Solicitor the Investigation Team's concerns about the report were enhanced because of the sense of frustration all of the above individuals related regarding its lack of clarity, and lack of evidence for a diagnosis of schizophrenia as well as Borderline Personality Disorder.

During the Investigation Team's interview with S3's Consultant Psychiatrist it was clear that he did not believe that S3 had Schizophrenia and that S3 had not displayed any signs of Schizophrenia during the nine weeks she was an in-patient in Liverpool. Her predominant behaviour was reported as adopting the maladaptive behaviour of others. Her named nurse also told the Investigation Team that while she was in Liverpool S3 picked up new self-harm methods that were 'old hat' to others. The impression the Investigation Team received from S3's Named Nurse was that S3's presentation was consistently more aligned to Borderline Personality Disorder than Schizophrenia and that he never saw any signs of psychosis in her. This nurse's opinion supports the opinion of S3's consultant psychiatrist and the opinion's of the various health and social care professionals who tried to engage with S3 in Sheffield.

When asked why he had not presented the information in his report to the court as clearly as he presented it to the Investigation Team at interview S3's Consultant C3 told the investigation team that he had thought the report was clearly presented. In addition he told the investigation team that he did not feel that he could completely disregard the opinion of the forensic psychiatrist who had assessed S3 in Newhall Prison and found features of her presentation that were suggestive of Schizophrenia.

When asked if he had been provided with any guidance on how to present his report, including previous clinical opinion and his own opinion, C3 told the InvestigationTeam that he had not. When asked if C3 was aware of or had ever seen the Civil Procedures Rules Practice Directions for Experts and Assessors he also told the Investigation Team that he had not.

This guidance under 'Form And Content Of Expert's Reports' Part 35 of the Practice Direction Experts and Assessors page 1 section 2.1 – 2.2 says[4]:

> 2.1 An expert's report should be addressed to the court and not to the party from whom the expert has received his instructions.
>
> 2.2 An expert's report must:
>
> - give details of the expert's qualifications
> - give details of any literature or other material which the expert has relied on in making the report
> - contain a statement setting out the substance of all facts and instructions given to the expert which are material to the opinions expressed in the report or upon which those opinions are based
> - make clear which of the facts stated in the report are within the expert's own knowledge
> - say who carried out any examination, measurement, test or experiment which the expert has used for the report, give the qualifications of that person, and say whether or not the test or experiment has been carried out under the expert's supervision
> - where there is a range of opinion on the matters dealt with in the report –
>
> (a) summarise the range of opinion
> (b) give reasons for his own opinion
>
> - contain a summary of the conclusions reached
> - if the expert is not able to give his opinion without qualification, state the qualification
> - contain a statement that the expert understands his duty to the court, and has complied and will continue to comply with that duty.

The Investigation Team lead also contacted the Royal College of Psychiatrists to find out if any guidance on the presentation of such reports is provided to its members, she was told that currently no such guidance is provided.

It seems to the Investigation Team that C3 did compile his report on S3 believing it to present clearly the historical opinions regarding S3 as well as his own clinical opinion. Had C3 been provided with clear guidance on the structure and format of his report the investigation team are confident that the frustrations experienced by the health and social care professionals in Sheffield would not have materialised.

[4] http://www.dca.gov.uk/civil/procrules_fin/pdf/practice_directions/pd_part35.pdf

The clinical records review showed no evidence that consideration had been given to taking S3 off all medications to try and achieve clarity in her diagnosis.

One of the ways to have achieved clarity in S3ôs diagnosis and to resolve the issue of whether or not she had any psychosis would have been to have been to have taken her off all of her medications and then to observe her behaviour. The Investigation Team were interested to know why this was not done given the predominant purpose of S3ôs compulsory admission to the low secure facility was to establish clarity in her diagnosis.

S3ôs Consultant, C3, told the Investigation Team that although he accepts that removing all medication would have been a valid assessment option in his opinion in S3ôs case he was unconvinced that this would have been of any real benefit. C3 told the Investigation Team that S3 was keen to continue with her medication and that she felt that it helped her. In such circumstances one has to weigh up the risk for the individual in removing such medication. C3 told the Investigation Team that he was mindful that stopping a patientôs medication can worsen the outlook if there is a psychotic illness and this would have been a reason for continuing with the medication in S3ôs case. Furthermore C3 does not believe that removing medication from S3 would have changed his clinical management of her at all.

Although the Investigation Team understands C3ôs rationale for his management of S3 the Consultant Psychiatric Advisor remains of the view that it would have been a viable option in her assessment and may have enabled a firm single diagnosis to have been made. However it must be emphasised that the Investigation Team are retrospectively analysing S3ôs management and that the Investigation believes that C3ôs management was reasonable.

6.0. CONCLUSION

The analysis of S3's care and management in Sheffield revealed that it was of the best quality one could expect of any NHS Mental Health Care facility at the time and there is nothing that the professionals in Sheffield could have done to avert the tragic incident on the 8th July 2004.

With regard to the perceived uncertainty relating to S3's diagnosis following her admission to the Low Secure Facility in Liverpool the Investigation Team does not believe that this made any material difference to the subsequent management of S3 by the Mental Health Service in Sheffield. However the Investigation Team cannot say whether or not S3 would have had a period of further detention at Newhall Prison. Discussions with her Solicitor at the time considers further detention to have been very unlikely. S3's greatest risk was to herself and she had displayed little aggression towards others during her nine week assessment period. Furthermore the Consultant Psychiatrist's advice at this time was that further detention in a secure facility was not in S3's best interests as she was mimicking the maladaptive behaviour of others and management in the community was therefore preferable.

The provision of services for individuals with Borderline Personality is challenging for two primary reasons:

- A willingness to engage is pivotal to the provision of therapeutic interventions to individuals with Personality Disorder. Unlike other mental health illnesses that are considered to be treatable therapeutic intervention cannot be successfully enforced.

- Nationally there is insufficient provision of evidence based therapies such as Cognitative Behaviour Therapy and for those individuals with Personality Disorder who are convicted and placed in a secure medical environment there are few such facilities that provide dedicated behavioural therapies. Individuals who go to prison are likely to receive no treatment whatsoever.

Furthermore without any direct threat of harm to a named individual neither the Mental Health Service, or the Police, have the power to detain an individual with Borderline Personality Disorder. This is because the nature of the illness makes them an uncertain and unquantifiable risk. Detention cannot occur without quantifiable risk or a treatable Mental Illness.

7.0 RECOMMENDATIONS

The Investigation Team has no specific recommendations to make for Sheffield Care Trust regarding the care and management of persons with Personality Disorder.

With respect to the Low Secure Facility in Liverpool the Investigation Team has three recommendations. These are detailed overleaf.

Recommendation1
Capio Nightingale Hospital Liverpool must ensure that where clients are admitted directly from the Court, or from Prison, and there is an existing mental health history and Community Mental Health Team involvement that it actively engages with the ôhome care teamô to commence discharge planning at the earliest opportunity regardless of the method of admission.

The Investigation Team accepts that this is the usual standard of practice for this facility and that the facility is committed to the Effective Care Coordination Approach. However this did not occur for S3 because her route of admission was unfamiliar to the service and there was it seems a lack of understanding regarding the limitation of an Interim Order made under Section 38 of the Mental Health Act.

Target Audience
The Clinical Services Manager

Recommendation2
That the Consultants and Senior Nurses at Capio Nightingale Liverpool consider if a trial of no medication is appropriate, where persons are compulsorily admitted for assessment and treatment, as a valid process to achieve clarity in diagnosis where Personality Disorder is considered but where uncertainty exists.

Although the Investigation Team accepts that not taking S3 off her medication was reasonable the Investigation Team remains convinced that this was the only way to determine whether or not there was any substance to the consideration of a dual diagnosis for her and that the removal of medication would have been a safe clinical option in the care environment S3 was in. The mixed diagnosis of Schizophrenia and Borderline Personality Disorder would have suggested an element of treatability for S3 and we remain convinced that this was not the case.

Target Audience
The Medical Advisor to Capio Nightingale Liverpool
All óAdult ServicesôConsultant Psychiatrists, Capio Nightingale Liverpool
The Clinical Services Manager, Capio Nightingale Liverpool

RECOMMENDATION 3
Given the importance of Psychiatric Assessments prepared for the Courts it is suggested that there are agreed local and/or national guidelines to assist Consultant Psychiatrists in the preparation of these.

Although the report provided to the Court in S3ôs case did meet the need of the Court in that it set out the recommendation of the Psychiatrist for the ongoing management of S3 it was not as comprehensive or as clear as it could have been.

The Investigation Team therefore recommends that within all mental healthcare facilities, on a local or regional basis, there is clear guidance available to Consultants on the format such reports should take and the range of information they should contain.

The Investigation Team suggests that such guidance should at least contain the following which reflects, and builds on, the guidance detailed in the Civil Procedures Rules, Practice Direction Part 35 Experts and Assessors[5]:

- ❑ The need for a front cover to the report that details who the report is about and who it has been written by and the date of completion.
- ❑ A section that sets out what the Consultant has been asked to provide.
- ❑ A section detailing the information that has informed the report.
- ❑ A section that details clearly the Consultant Psychiatrists assessment of the person and how the assessment has been conducted, including observation of the personôs behaviour.
- ❑ A section that clearly states the Consultant Psychiatrists assessment of the person and how the assessment has been conducted, including observations of the persons behaviours.
- ❑ A section detailing the opinion of the Consultant in terms of diagnosis, risk, treatability, optimal placement, and key considerations for any future care package.
- ❑ A section detailing the experience and qualifications of the Consultant Psychiatrist

[5] http://www.dca.gov.uk/civil/procrules_fin/pdf/practice_directions/pd_part35.pdf

The Investigation Team appreciates that the most pragmatic approach will be for each Mental Health organisation or for NHS Yorkshire and the Humber to generate local guidance. However the Investigation Team encourages NHS Yorkshire and the Humber to consider raising the need for such guidance with Professor Sue Bailey College Registrar at the Royal College of Psychiatrists.

The Target Audience is therefore:
The Medical Director and Director of Governance at Sheffield Care Trust
The Medical Advisor to Capio Nightingale and the Clinical Services Manager at Capio Nightingale Liverpool
Director of Nursing and Patient Care at NHS Yorkshire and the Humber.

APPENDIX 1

CHRONOLOGY OF S1'S CONTACTS WITH THE MENTAL HEALTH SERVICES PROVIDED BY SCT AND THE LOW SECURE FACILITY IN LIVERPOOL

Date	Event
23/10/02	S3 was first admitted to the Mental Health Service under Section 2 of the Mental Health Act following her admission to accident and emergency after taking a serious over dose. The medication she is believed to have taken is; ❑ 30 Kapake (500mg) ❑ 32 Paracetamol (500mg) ❑ 50 Ibuprofen (400mg) ❑ 28 Dihydrocodene (30mg) ❑ 7 Fluoxetine (20mg)
25/10/02	S3 was assessed by a member of the Deliberate Self Harm (DSH) Team. This assessment revealed that S3 had experienced some problems over the previous months and had been prescribed Fluoxetine by her GP. S3 was noted to be órather uncooperative thought the interview and difficult to engage.ôS3 it seems was unwilling to reveal much about herself. The lack of eye contact noted was considered to be a feature of S3 not wanting to engage rather than as a result of any depression. During the assessment S3 told the DSH Team Member that there were no problems at work and she gave no indication that there were problems at home. Her social life was what one would expect of a 17 year old (going out with friends on a regular basis). The assessment makes clear that the quantification of S3ôs continuing risk factor was difficult to determine because of her unwillingness to engage. Following the assessment S3 was given contact details for the DSH Team in case she wanted more support. She was also referred back to the medical team and the in-patient ward was advised to contact the Column III Psychiatrists[6] if they were at all concerned over the weekend.
30/10/02	S3 is reviewed and tells staff that 18 months previously she had a relationship with a boy who was already involved with another girl. Consequently they ósplit upô S3 told staff that as a result of the ósplit-upôthis boyfriend committed suicide. The notes reveal that S3 blamed herself for this, and that this was exacerbated by the fact that the boyôs other girlfriend also blamed her.

[6] Column III doctors refers to on-call doctors and those responding to casualty calls.

Date	Event
30/10/02 cont	S3 apparently had come to terms with what had happened over the past months but had not really spoken to anyone other than a close girl friend. The anniversary of the boys death was on the 10th October and then on the 23rd of October she bumped into the other young woman who, the records note, was apparently quite unpleasant to her. This it seems precipitated her overdose. S3 is noted to be upset and saying that she wants to go home. S3 was also assessed by the Consultant Psychiatrist for the in-patient ward (C1) who agreed with the nursing assessment and for S3 to be discharged home.
23/12/02	S3 attends for an out-patient appointment with her allocated Consultant Psychiatrist (C2). At this appointment she is noted to be cheerful and forthright and not showing signs of depression. It is noted that she does not like talking to strangers and she has people she can talk with. The records note that the issue that prompted the over dose in October 2002 is now under control but remains. However S3 would not divulge more. It is noted that S3 advised that she would not over dose again.
23 /12/02	The plan for S3 is for discharge from the mental health service with no follow up.
10/02/03	A referral is made from the on-call doctor to the West CMHT. This letter provides an appropriate summary of S3ôs admissions to hospital on the 7th and 8th February following overdoses of tablets. The letter also makes clear that S3 displays no signs of mental illness. The SHO also says ñWe advise that she (S3) be referred to the Adult Mental Health Team for further psychological input. I discussed this option with the patient and apparently she agreed to be engaged in a sort of therapeutic relationship with a professional in the sector.ò
18/02/03	S3ôs GP is informed that she has been accepted as a patient by the West CMHT and that she is to be seen by a team member at the Limbick Centre.
21/02/03	S3 is again assessed on a medical ward at the Northern General Hospital by a Psychiatric SHO. Following a further overdose. Again S3 is noted to refuse to discuss the reasons why she took the overdose. S3 is noted not to show any evidence of suicidal ideation but ósshe stressed that she could not guarantee she would not do it againò

Date	Event
21/02/03 cont….	Because this is S3ôs third attempt in six months, without any evidence of clinical depression, it is noted that S3 is advised that she might benefit from counselling. The letter states ñShe has however again turned down this offerò The letter also notes that S3 ñeventually stormed out of the interviewò S3ôs management is discussed with Consultant Psychiatrist C1 who suggests that intensive community follow up might be of more benefit. S3 is sent an appointment with Consultant Psychiatrist C2 for the 24th February. There is no evidence that she attended.
24/03/03	Consultant Psychiatrist C2 writes to S3ôs solicitor advising that she is formally accepting the role of RMO (Responsible Medical Officer) for S3 and that she is liaising with SW1 to devise a care plan.
01/04/03	There is correspondence between the West Sector CMHT and S3ôs GP that shows that S3 has again been accepted by this team. There is also a letter to S3 inviting her to an assessment appointment on the 6th May 2003. S3 did not attend for this appointment.
03/04/03	There is a letter to Consultant Psychiatrist C2 from the Sheffield Youth Offending Team advising that S3 had spent approximately six weeks on remand at Newhall Womenôs Prison following arrests on three consecutive days for criminal damage directed to one family. The correspondence also highlights the concern of S3ôs mother that there were several instances of self harm while S3 was on remand. In addition assaults on staff members is also identified, the nature of which was ôthrowing chairsôand on occasion the throwing of boiling water. The author of this letter says ñI personally have had little contact with S3 yet her behaviour both in the community towards her victims, and the threat of self harm to herself whilst on remand, obviously raises a great deal of concern in me in terms of her own safety and the safety of othersò
04/04/03	S3 was in attendance at the Magistrates Court. She was remanded back to the care of a named individual with a request for a Psychiatric Report to be prepared for her next Court appearance on the 25th April. It is clear from this letter that S3 was at this time refusing any interventions, even from the Psychiatrist attached to Newhall Prison where she had been remanded to.

Date	Event
29/04/03	Correspondence between the Youth Offending Team and the West Sector CMHT shows that S3 had appeared in Court on the 25th April and was bailed to her step fathers residence until the 9th May which was the date she was next due to attend the Court.
08/05/03	S3 did not attend her Out-patient appointment.
18/05/03	S3 was admitted to accident and emergency following an overdose of Kapake in the early hours of the morning (approximately 04.14). S3 had also been drinking heavily. She was found collapsed at a friends house, responded to painful stimuli but otherwise was initially non-responsive but maintaining her own airway. Following her admission to hospital at around midday S3 was found with a plastic bag, oxygen tubing and latex gloves tied around her neck. These were removed from her and the slight cyanosis resolved quickly with oxygen. At approximately 15.25hrs S3 was assessed by a member of the Column III Team. She tells the Column III (CIII) team member that she had drunk quite a bit as she ócanôt forgetô She tells staff she was assaulted last October but does not divulge further. She does however tell staff that she often drinks and she is sometimes shaky in the morning. S3 told staff that her overdose was not planned, it was óon the spur of the momentôbut that she ósstill wants to dieôand feels hopeless about her future. S3 also tells the CIII team member that when she is upset she hears a voice telling her to harm herself. It is a male voice and a single voice. On questioning she was not sure if the voice could be her own thoughts. The CIII team member also establishes that S3 has not been talking to her mother. Information is however gathered from S3ôs mother and her step father. The perception of both is that she is drinking more. The plan following this assessment is to admit S3 to the in-patient ward for respite with no leave and then for referral to the community mental health team (CMHT). S3 denies any thoughts of harm to others.
19/05/03	A full history is taken from S3 by a Pre-Registration House Officer (PRHO). This history confirms much of the detail provided to the CIII Team Member, however there is an anomaly in S3ôs recounting of her experience of being raped the previous October. She tells the PRHO that this happened twice. **Note:** This is the start of many inconsistencies in the information that S3 provides to the healthcare staff.

Date	Event
19/05/03 cont….	S3ôs mother also advises that S3 has had difficulties since the age of 13years, specifically difficulty in controlling her anger and lying. S3ôs mother is not convinced that her daughter has been raped, she has seen no evidence to suggest it. S3ôs mother also tells the ward staff that she thinks her daughters suicide attempts can be exaggerated. She also feels that S3 likes to be contained as she gets more attention. She believes that her daughter liked prison because of this. S3 has been seen by a Psychologist who S3ôs mother believes thinks S3 is depressed. S3ôs mother says that she does not see much evidence of depression in her daughter. A feature of this assessment is S3s reluctance to go into any issue in detail. The plan therefore is to continue with her medication and to discuss future management with Consultants C1 and C2.
19/05/03 Cont…..	S3 is assessed by Consultant C1. The outcome of these assessments is some confusion regarding the reliability of S3ôs history of being raped. There are also some concerns about childhood issues. The multi-disciplinary team agree that more background information is needed from S3ôs mother and step-father. It is also noted that the fracas she was involved in the previous August must have been reasonably serious for it to attract a three-month custodial sentence. The definitive plan at this stage was: ❑ To get more information about S3ôs childhood including from school. ❑ To find out why she is to appear in court this coming Friday. ❑ To plan to discharge S3 soon, and to reduce the 5 minute nursing observations to a frequency to be decided at ôthe nurses discretionô ❑ To consider Rape Crisis/Womenôs Therapy.
21/05/03	The CIII Teams House Officer (HO) was asked to assess S3 at 21.00hrs following an incident where she had tied her shoe laces around her neck and to the tap in her room. S3 told staff that she did this to make the voices in her head stop. S3 shouted for help as she could not undo them. Once the shoelaces had been cut off S3 went to the ôseclusion roomô to take her aggression out on the padded furniture.

Date	Event
21/05/03 cont…	She settled with no further suicide ideation. The clinical impression was that this was not a serious suicide attempt but that S3ôs risky behaviour could lead to accidental self harm. S3ôs parents arrived on the ward during the assessment and her mother reiterates S3ôs previous behavioural problems of lying, stealing and aggression. S3ôs mother also advised staff that while S3 was in prison her incidence of self harm increased and that there were episodes of violence against the staff. A diagnosis of Borderline Personality Disorder with trauma has been diagnosed by the Clinical Psychologist. The Clinical Psychologist also considers S3 to be high risk.
22/05/03	A member of the Youth Offending Team confirmed that Consultant Psychiatrist C2 and a Social Worker (SW1) will meet with S3 on the 2nd June. S3ôs court case due on the 23 May is to be adjourned pending C2ôs assessment. A telephone conversation Between the In-Patient Consultant Psychiatrist C1with the Clinical Psychologist[7] on the same day revealed that: ❑ S3 does not accept responsibility for her behaviour ❑ S3 has limited cooperation ❑ it is likely that S3 has suffered child hood trauma The long term treatment is suggested as psychotherapy and that there is a long wait for this. The clinical psychologist, the notes indicate, believes that S3ôs needs cannot be met by the CMHT, and there is no statutory service in Sheffield that can offer treatment. The CMHT can offer S3 support if she will accept this, however it is important that there is a distinction between ótreatmentôand ósupport and managementô The notes state clearly that the treatment required for S3 ñis psychological and unlike mental illness cannot be imposed ï need a willing customerò. Consultant C1ôs records are detailed and extensive. At this stage all assessments are consistent in finding no evidence of psychosis.

[7] S3 was assessed by the Clinical Psychologist on the 17th and 29th April 2003 at the request of S3ôs Solicitor. The final report was written on the 4th May 2003.

Date	Event
22/05/03 cont…..	Consultant C1 also speaks to S3ôs mother who reveals that much of what S3 has told the mental health team about looking after horses and family issues is untrue. The notes evidence a lengthy conversation with S3ôs mother that covers issues relating to S3ôs childhood, her adolescent years and the contemporary situation.
23/05/03	S3 is informed that she is to be discharged home and that she will have long-term follow up in the community with Consultant C2 and SW1. S3 became upset when advised of her discharge as she had only been an in-patient for four days. She tells the HO that she does not feel that she can manage at home. When S3 is told that she does not have a mental illness her response is ñyou are telling me everyone like me hears voicesò. S3 is adamant that it will not be enough only seeing someone once a week. The House Officer (HO) plans to discuss the situation with Consultant C1. Following discussions with Consultant C1 it is agreed that the HO can negotiate with S3 to allow her to stay as an in-patient until the 2nd June providing the following conditions were met: ❑ No DSH ï she must talk to the nursing staff if she feels she is going to self harm. ❑ No aggression towards staff / patients. Any incidents will be dealt with by the police. ❑ No drinking alcohol. ❑ No sexual relationships with other patients. S3 is advised if she does any of the above then she will be discharged.
27/05/03	The CMHT records note that S3 is due to have an appointment with her Care Coordinator (SW1) and Consultant Psychiatrist C2 on the 2nd June and that S3ôs court hearing has been adjourned to allow this to happen. The record also notes that S3 does not always attend appointments, though this is sometimes because she is in prison. Sw1 also notes that S3 is able to live within rules and has demonstrated this ability during her present in-patient episode.

Date	Event
29/05/03	Medical Review:- It is noted that S3 has been well on the ward with no further attempts at DSH or aggression toward staff. S3 is reminded that she is to be discharged on the 2nd June and that she needs to prepare herself for this. S3 still does not think she will cope at home but accepted the agreed date. The plan at this time is for S3 to continue to reduce her diazepam as she will not be discharged on this.
02/06/03	There is a MDT ward round with Consultant Psychiatrist C1 on this day. S3 refused to get out of bed to go to her appointment with Consultant Psychiatrist C2 and therefore missed this opportunity to develop her care plan. The in-patient plan remains for S3 to be discharged. The records also note that S3 continues not to take any responsibility for herself and that S3 had made superficial cuts to her wrist with a safety pin the night before and was also inciting other patients to be against the nursing staff. The plan documented states: ❑ that a letter needs to be sent to S3ôs GP, A&E, the Out of Hours Team and SW1 and Consultant Psychiatrist C2 advising of S3ôs diagnosis of Borderline Personality Disorder and Anti-social traits, that S3 is not mentally ill and treatment therefore is of no benefit. The notes also seem to suggest that the letter should highlight that S3 did not attend her meeting with Consultant Psychiatrist C2. ❑ Consultant Psychiatrist C2 to follow up if ósheô chooses. It is not clear whether this is if S3 chooses or if C2 chooses. Consultant Psychiatrist C1 goes to see S3 prior to her discharge and asked her why she did not attend her appointment with SW1 and Consultant Psychiatrist C2. S3 said she did not know anything about it. C1 was aware that SW1 had visited S3 to talk to her about the appointment and that ward staff had also reminded her about it that very morning. When challenged S3 said she could not go alone. Consultant Psychiatrist C1 told S3 that ôthis was ridiculousô S3 then stormed out. The Consultant Plan as documented was: ❑ For S3 to be discharged as planned, and to be escorted off the premises if she refuses. ❑ Any criminal damage to be charged. ❑ No follow up from me (P.D and not willing to engage in any change).

Date	Event
02/06/03 cont….	Consultant Psychiatrist C1 speaks with Consultant Psychiatrist C2 and explained the position. Consultant C1 also notes that she will write to the Out Of Hours Service advising against re-admission. The records also state ñIf at any time in the future S3 presents and is willing to attend an appointment with Consultant Psychiatrist C2 or SW1 then she can be offered one.ò
03/06/03	S3ôs Solicitor contacts the CMHT and is advised of S3ôs missed appointment and discharge. He advises that he will be seeing her that afternoon.
04/06/03	S3 attended the Limbrick Centre without an appointment. SW1was able to speak with her on the phone but could not accommodate a face-face meeting at this time. The community record suggests that S3 was challenging and argumentative on the phone and eventually put the phone down and left the building. SW1 records that she is not offering S3 another appointment prior to her court appearance (in four days time) as she (S3) knew she had appointment on the 2nd June. The rationale for this was the need to maintain very clear boundaries with S3 especially as she had agreed to her bail conditions and that she would attend appointments to enable the Court Report an care plan to be written.
30/06/03	The CMHT is advised by the Court Liaison Service that the Court has not taken S3ôs case forward because of her non- attendance at the planned appointment with Consultant C2 and SW1.
08/07/03	S3 is referred to the DSH Team at 09.10hrs following an overdose of: ❑ Paracetamol x20 ❑ Zopiclone x15 ❑ Diazepam x15 ❑ Venaflaxine x15 All of which were taken two days previously. S3ôs Paracetamol levels were greater than 142. It seems that S3 was very depressed following the death of her boyfriend and wanted to be with him again. The Senior House Officer (SHO) assessment details S3ôs rationale which reflects information shared in October 2002. The key difference is her previous boyfriendôs mode of death. In October 2002 S3 told staff that he had hung himself and on this admission she told the SHO that he had taken an overdose.

Date	Event
08/07/03 cont….	Prior to this overdose S3 sent her friend a text message who found her and brought her to the A&E department. The SHOôs records note that S3 is not regretful that she took the over dose but was remorseful that it was not successful. S3 tells the SHO that she will make more attempts in the future. S3 also claimed at this time that she was hearing her ex-boyfriendôs voice all the time. She was unable to hear his voice during the interview with the SHO. When asked if she would accept an in-patient assessment S3 is ambivalent. The SHO discusses S3 with Consultant Psychiatrist C1 re. psychiatric management. From a medical perspective S3 cannot be discharged as she remains on Parvolex. The outcome of the SHOôs discussion with C1 is that no psychiatric in-patient assessment is warranted and therefore no admission is necessary. S3 is to be advised to make an appointment with SW1. (The records note that SW1 is not available that week and S3 is advised of this and also provided with the Out of Hours contact details.
10/07/03	S3 makes contact with the CMHT. She says she cannot cope with her óunbearable feelingsôand óbeing forced to leave Vickers 5ô The records show that the Duty Worker made contact with Consultant Psychiatrist C1 who is noted to have said that óS3 will not benefit from admissionô A message was also left for S3ôs Care Coordinator (SW1). S3 is offered an appointment for the next day. S3 does attend this appointment. She asks for admission as she felt it did help. The Duty Worker discussed with S3 the reasons for the decision that admission was not the best thing for her in some detail. S3 insisted on a second opinion and it was agreed that this would be arranged for her. S3 refused to leave the building as óno help was being offeredô The Duty Worker went through in some detail the community services and that ongoing one-to-one work with a therapist was believed to be the most helpful for S3. S3 would not accept this. After about 20 minutes of trying to encourage S3 to leave the building she was informed that the police would be called if she did not leave. After a further ten minutes S3 left the building voluntarily. The Out of Hours Service were informed of the events by the Duty Worker.

Date	Event
18/07/03	S3ôs worker at Victoria Court (a supportive housing project) phoned the West Sector CMHT advising that S3 is now saying that she will accept therapy and could she be sent an appointment. S3ôs Support Worker was informed that an appointment would be sent to S3 within the following two weeks. (On the 13th July S3 had refused contact with the services)
29/07/03	S3ôs Probation Officer makes contact with S3ôS CMHT. He advised the Mental Health Team that he will see her every week for three months.
26/08/03	A Mental Health Worker from the Out of Hours (OH) Team advised the South West CMHT that the previous week S3 had locked two OH Team members in her flat for 30 minutes until the police arrived. It appears that S3 had a knife on her at the time which she did try to hide from the team. She was arrested. The clinical records note that ña warning has been posted on INSIGHTô On the same day is a record advising that S3ôs care has been reallocated to an other Care Coordinator (CC2). The records show that the CMHT did try and make contact with S3ôs mother at this time. **Note:** S3 did not hold the OH Team members at knife point but the presence of a knife on her person was extremely concerning.
29/08/03	SW1 and a colleague went to see S3 following concerns raised by staff at Victoria Court. These concerns focused on her self-harming, and the concern of workers at Victoria Court that S3 is not getting help with her mental health problems. The records note that S3 was not willing to talk about anything and would turn away to look out of the window or say she didnôt know. It is noted that S3 was tearful at the end of the interview but would not say why. It is noted that SW1 spoke to S3 about her new Care Coordinator and the need to have a plan of work and to stick with this. After the interview had been terminated a worker from Victoria Court phoned and advised that: ❑ S3 did not understand why she could not return to hospital. ❑ That ñsomeone (male) was taken away from her by everyone but it was not clear who. ❑ Fears that diagnosis is ñattention seekingôand that people think ñI am stupidò

Date	Event
10/09/03	S3 is now registered with another GP Surgery and being prescribed Venaflaxine on a weekly basis. On this same day S3ôs mother cancelled an appointment with CC2 as S3 had been admitted to hospital with an infection. On the 12th October S3 made contact with her new Care Coordinator. S3 is again saying that she can not cope and that she has had enough ï she does not feel that she can last the weekend. When asked she said that ópeople were attempting to get into her flatôbut she could not identify who or whyô S3 also indicated that she was now seeing things as well as hearing them. E.g. People were in her flat and saying unpleasant things to her. She said that she had tried to distract herself but now cannot cope. Says she is ósseeing people all the timeôand she is angry and upset that no-one believes her. Care Coordinator CC2 told S3 that he needed to talk to colleagues that knew her situation better than he, and he would get back to her. These enquiries revealed that S3 had been assessed that week and that there had been no evidence of delusional beliefs and that her diagnosis is one of Personality Disorder and that medical opinion is that delusion/psychosis is unlikely. Care Coordinator CC2 discussed the matter with his manager and it is agreed that he needs to initiate his involvement in a structured and organised way. His plan was to: ❑ See S3 the following Thursday. ❑ Initiate medical re-examination of psychosis. ❑ To request out-of hours to make telephone contact with S3 over the weekend to offer verbal support. Care Coordinator CC2 makes contact with S3 to advise her of the plan. She was unhappy with this and put the phone down. As a result the Care Coordinator agreed with the Out of Hours Service that they would call S3 at 7pm that evening to see if she had calmed down. Subsequent contact between Care Coordinator CC2 and S3 resulted in S3 accepting the plan of action.

Date	Event
16/09/03	S3 again attends the A&E department at the Northern General Hospital. On this occasion she has taken no over dose but reports feeling suicidal. She initially called the GP cooperative and she was advised to attend A&E. S3ôs mother also makes contact with the CMHT concerned for the welfare of her daughter. This is followed up immediately by the Duty Worker. A Project Worker advised that S3 is in the office with them and unsettled but that there is no evidence of self harm. The Duty Worker tries to make contact with SW1 who it is noted had had a conversation with S3 in the 10minutes preceding the Duty Workerôs contact with the project. The Duty Worker also makes contact with S3ôs mother who is concerned about her daughterôs circumstances and questioned whether she should be admitted to hospital. It is noted that S3ôs mother was aware that S3 could be óextremely manipulativeô It is also noted that S3ôs mother was under the impression that the recent hostage taking by S3 was óanother one of her liesô She was advised that it was not. Telephone contact is made again with S3 later in the day. She is now back in her flat and has no plans for the evening and again talked about needing to move from Victoria Court. The Duty Worker advises S3 that admission to hospital is extremely unlikely and reminds her that she has an appointment with her current Care Coordinator on the Thursday. The Duty Worker also advised that he/she will ask a colleague to make contact with S3 the following day.
17/09/03	S3 is assessed by the SHO for CIII Team. The assessment details in brief S3ôs previous attempts at DSH. It also shows that S3 is saying that she is seeing people in her flat ï she sees the outline of a person, nasty looking. She says she sees them everyday. They tell her to harm herself. The SHO also notes that S3 is due in court on the 20th October for holding two mental health workers hostage. S3 says she has no memory of the incident. S3 also tells the SHO that she would not be able to cope with going home that evening.

Date	Event
17/09/03 cont….	S3 tells the SHO that she knows that she will do something to harm herself. The records also note that she told the SHO that she did not want an in-patient admission but can not cope going home. The impression of the SHO was that S3 did have some features of emotionally unstable personality disorder, borderline type. There were also features of depression and those associated with waiting her court appearance for assault. Following discussion with a senior colleague the plan was for: Admission with normal level observations to Ward 2. Medication is PRN Haloperidol, Lorazepam, and Zopiclone. **Note:** On this same day a CMHT member was trying to arrange for S3 to see Consultant Psychiatrist 2 in out patientôs the same afternoon. This individual tried to call S3 at 08.45 and at 10am and subsequently learnt that she was on one of the in-patient wards.
18/09/03	Consultant Ward Round with Consultant Psychiatrist C3. At this time S3 denied traumatic events at home. She claims to see dark figures and that she is scared, lonely and miserable. The MDT record says that ósstaying in hospital is not going to helpô The record also notes that S3 has an appointment with SW1. The notes detail a careful exploration by C3 of S3ôs voices and visions. It is also noted (as with previous examinations) that S3 does not appear to be disturbed by any hallucinations during the assessment. S3 reiterates that she wants help to move from her ópresent accommodationôto the Half-way house. This it is noted is being progressed by the CMHT and S3 is due to move to the Half-way House the following Friday.
19/09/03	S3ôs Care Coordinator (CC2) visits her at Victoria Court. S3 is noted to be calm and was able to maintain eye contact at times during the conversation but that she was also distracted/nervous in her manner and avoiding eye contact. The records show that the issue of alternative housing was discussed. It is also noted that S3 believes that going to her Stepfatherôs is no longer an option. CC2 talked with S3 about the need to address practical issues and that he would initially like to meet with S3 on a weekly basis. By the 8/10/03 S3 had moved into a new residence.

Date	Event
08/10/03	It is noted that S3 had, had a session with Consultant Psychiatrist 1 and that S3 continues to be unwilling to talk about her feelings. It is also noted that this Consultant feels that a female care coordinator would be more appropriate for S3.
13/10/03	Care Coordination 2 (CC2) visits S3 in her new accommodation with a female colleague. CC2 notes that S3's rapport with his colleague is better than it is with him. She has better eye contact. CC2 also notes that S3 seems happy with her new accommodation and can get out more easily. Weekly meetings with CC2 to continue.
15/10/03	CC2 notes that S3's GP is concerned about where the overview of S3's medication is occurring as she is only a temporary resident at the GP surgery. As a result CC2 makes contact with the previous medical centre S3 was registered at. He is advised that the records had been requested on the 11th October. CC2 also speaks with Consultant Psychiatrist 1 regarding S3's medication. This Consultant it seems would have been reluctant to prescribe S3 any medication.
21/10/03	S3's court case is deferred for a further month while a Psychiatric report is prepared. S3 is informed by CC2 that she will face a significant prison sentence possibly 12-18 months. (re. hostage event). S3 continues not to engage fully with probation or the structures at Halfway. CC2 attempts to contact S3's RMO Consultant Psychiatrist C2.
23.10.03	CC2 successfully liaises with Consultant Psychiatrist C2. Her advice is that S3 should not be prescribed Diazepam. Temazepam to be prescribed instead. Also in view of some features of depression S3 could have Seroxat and 1mg of Rispiridone. The consultant was to write to S3's new GP.
27/10 – 3/11/03	There is an escalation in S3's anger about the lack of support being offered to her. The Care Coordinator's notes evidence good efforts to try and find out what type of help S3 feels she needs. Her focus is on practical issues and she refuses to talk about anything personal. The impression is that S3 is confrontational. No progress is made. This episode culminates in S3 being arrested at a Night Club and subsequently re-arrested in A&E where she had been allowed to attend because of injuries sustained to her leg. Psychiatric assessment revealed that she was not thought to be suffering from thought disorder or psychosis. S3 currently prescribed Seroxat and Lorazepam (to be reviewed by Consultant Psychiatrist C2). Staff at Halfway (supported accommodation) contacted to provide support to S3.

Date	Event
04/11/03	S3 remanded in custody until the 25th November 2003. Following this the Court Diversion and Liaison Nurse makes contact with CC2 to discuss options for S3 as a community disposal may not be considered appropriate. Possibility of detention within a therapeutic facility discussed. S3's mother is advised of situation. CC2 confirms to S3's mother her daughter's diagnosis and provides an explanation to her of the relationship between personality development, vulnerability and stress. S3's mother advised that S3 may have another change of Care Coordinator as a result of her change in accommodation and GP.
23/12/03	S3 remains on remand. Am Interim Hospital Order to a low secure hospital admission is being considered to allow for a full assessment of S3. S3's case is adjourned until the 29 January 2004. During this time the Court Liaison and Diversion Nurses liaise with the Secure Services Commissioning Team to ensure that S3 is assessed and a decision can be made regarding the type of secure facility that will best meet her needs. The outcome of this is that S3 is to be placed in a Low Secure Facility. Because single sex accommodation could not be guaranteed at the Low Secure Facility in Sheffield and 'Safe Spaces'[8] did not feel that S3 was a suitable candidate for their service alternative provision was sought.
14/01/04	S3's mother is advised of S3's right to confidentiality as she is trying to assert her right to information about her daughter.
March 2003– 06/05/04	S3 is admitted to a Private Low Secure Facility in Liverpool under Section 38 of the Mental Health Act. The purpose of this admission was to enable a full assessment of S3. In addition the documentation accompanying the assessment and acceptance of S3 said it would offer: ❑ Individual 1:1 intervention ❑ Psychological intervention as required ❑ Social and personal development ❑ Access to identified therapeutic interventions/activities ❑ Facilitating family visits ❑ Addressing basic educational needs ❑ Pharmacological intervention as required. During the nine weeks S3 was an in-patient at this facility there were 10 reported incidents of self-harm ranging from head banging to the swallowing of a battery and insertion of a pen into her arm on the 6th May

[8] This is a private low secure facility for women.

Date	Event
March – May 2004 cont….	(the date of her discharge from Section 38 of the Mental Health Act). Her end diagnosis was Borderline Personality and Schizophrenia. (**Note:** The Investigation Teamôs interview with her Consultant Psychiatrist at this hospital revealed that no signs and symptoms of Schizophrenia were identified during S3ôs nine week admission. However he felt that he could not discount it as a diagnosis because another Forensic Consultant Psychiatrist had reported some evidence of this in his assessment of S3 in prison. The information provided by staff that cared for S3 revealed that she was relatively settled at the unit but was influenced by the behaviour of others. She had a tendency to mimic the behaviours of others. The staff likened it to a competition to see who could gain the most attention from the staff or be the most dramatic in their acts of self-harm. In spite of these behaviours it seems that S3 was reasonably well settled in Liverpool with little evidence of aggression and was well liked by the staff there.
06/05/04	S3 re-attended Court as planned and she was discharged from the hospital order. It is noted in the nursing records of the Low Secure Facility on the 7th May that S3 was anxious about going home but better about it than before. She plans to see her friends and in about a month wants to ósort out collegeô **Note:** On the 5th May the Court Diversion and Liaison Nurse liaised with S3ôs CC2 in Sheffield. The possibility that S3 may be discharged was highlighted. CC2 also discussed the situation with Consultant Psychiatrist C1[9] who was clear that a service should not be offered to S3 on the basis of a court direction that she should engage (historically S3 had not complied with formal directives).
14/05/04	S3 is visited at home by CC2. Her recorded behaviours reflect those prior to her admission to the low secure facility. S3 did report that voices told her to harm herself but would not describe these when asked. S3 also re-referred to Halfway House.

[9] At this time Consultant Psychiatrist C2 was on sick leave and Consultant C1 took over the lead responsibility for S3ôs management.

Date	Event
01/06/04	Halfway House, a Residential and Community Mental Health Support project, write to S3 advising that she is on their waiting list. This letter also advises S3 to try and seek some form of therapy around self-harm.
03/06/04	There is a full and detailed review of S3ôs contact with mental health services and her behaviour from October 2002 to date. This analysis formed the basis of a report on S3 that Consultant Psychiatrist C1 complied on the 8 June 2004. This 11 page report concludes with a nine point plan and highlights this consultants (Consultant Psychiatrist C1) concern that S3 does pose a risk to others, albeit unquantifiable. The plan also contains clear guidance regarding future contact with S3 ie in a public place and with two workers. S3 is placed on Enhanced CPA to enable good communications between agencies and best access to services for S3.
04/06/04	There are issues regarding S3 registering at a GP practice ï GPôs not happy to accept. Also S3ôs Probation Officer is to be seeing S3 weekly. This officer is advised that S3 being on Enhanced CPA is not to be used to enable S3 to avoid taking responsibility for self. S3 currently staying with a friend and registered homeless. Enhanced CPA explained to S3 on the phone ï in response to a question from her. She terminated the call.
16/06/04	Liaison with S3ôs mother. S3 has had to leave her Stepfatherôs after suspicion of theft. S3ôs mother noted to be surprised by the package of care required for her daughter as ósheô sees S3 as being largely capable and doesnôt see her as suffering form Schizophreniaò. S3ôs mother confirmed that S3 was living with a friend and that she had been to the Homeless Section. CC2 confirmed that he was still available to work with S3.
17/06/04	S3ôs Probation Officer advised that S3 had cancelled her appointment with her. She also advised that she was hoping to arrange a multi-agency risk/planning meeting in August.
18/06/04	CC2 makes telephone contact with S3. She is ambivalent. As she is with her Probation Officer she agrees to call him back.

Date	Event
28/06/04	The national Probation Service writes to S3ôs Care Coordinator requesting his attendance at a Level 2 MAPP (Multi Agency Public Protection) Meeting that is to take place on the 10th August 2004 at 10am. The purpose of the this meeting was to: ❑ Share information. ❑ Agree the risk assessment. ❑ Agree plans to manage the assessed risk.
30/06/04	S3 inflicts a deep cut to her arm with a craft knife damaging a tendon. S3 indicates that she had not meant to cut so deeply. On this same day S3 calls her Care Coordinator (CC2) wanting to know if she can access a self-harm group. S3 also reveals that she wants a female CPN. CC2 agreed to arrange an appointment to discuss S3ôs issues at a CPA meeting.
01/07/04	CMHT ï Team Meeting. CC2 requested assistance/joint allocation from a female team member on the basis of S3ôs request and Consultant Psychiatrist 1ôs recommendation that S3 should be seen by two professionals. There was no female CPN with the capacity to provide the support required. S3ôs previous Care Coordinator, SW1, therefore agreed to assist. A meeting was agreed with S3 for the 7th July.
07/07/04	CC2 and S3ôs previous Care Coordinator CC1 meet with S3 at the Limbrick Centre. This meeting lasted an hour and generated six pages of notes. Owing to the length of the meeting and the range of issues discussed with S3 they agreed to meet again on the 25th July. In the interim period SW1 and CC2 were to undertake the actions they had agreed. The impressions of SW1 and CC2 at the end of the meeting were: ❑ Good engagement by S3 in the conversation. ❑ S3 not distracted by hallucinations or dissociation. ❑ S3 sometimes tearful and frustrated ï especially when not wanting to accept Consultant Psychiatrist 2ôs assessment ❑ No signs of overt anger, no direct aggression and no direct threatening comments or behaviour from S3.
08/07/04	CC2 advised by CID that S3 had been arrested on suspicion of stabbing another girl in the early hours of the morning.

APPENDIX 2

SOURCES OF INFORMATION ACCESSED

To underpin the findings and recommendations of this investigation there were five main sources of information:

- The information shared by people at interview.
- Information gleaned from a broad and detailed document review.

The initial review of clinical, police and court records was undertaken prior to the interviews and group meetings so that the Investigation Team could be quite clear regarding the range of issues to be explored on an individual or group basis at interview.

The following tables detail the full range of personnel interviewed and documents accessed and utilised during the course of the investigation:

Table 1 Staff employed by Sheffield Care Trust

Reference code	Designation	Interviewed By	Date Interviewed (all in 2006)
SW1	Approved Social Worker and Care Coordinator S3	Maria Dineen and Dr Mark Potter	10 May
CC2	Approved Social Worker and Care Coordinator S3		
Cons 1	Consultant Psychiatrist to S3		
Cons 2	Consultant Psychiatrist to S3	Maria Dineen and Dr Mark Potter	11 May
	Court Liaison and Diversion Nurses		
	Clinical Nurse Manager Forensic Services		

Table 2 Staff employed by Capio Nightingale Low Secure Unit Liverpool

Reference code	Designation	Interviewed By	Date Interviewed (all in 2006)
Cons 3	Consultant Psychiatrist to S3	Maria Dineen and Dr Mark Potter	31 May
CC2	Named Nurse to S3		
Cons 1	Staff Nurse who care for S3		
Cons 2	The Clinical Services Manager	Maria Dineen and Dr Mark Potter	

In addition to interviews with the staff two members of the Investigation Team visited the ward where S3 was cared for during the period of her interim hospital order. The care environment was bright and well managed with all patients having spacious rooms with ensuite facilities.

In addition to the staff working within the respective mental health services the Investigation Team met with:

- the Family Liaison Officer to the family of S3ôs victim
- S3ôs mother
- Team Leader of the Secure Services Commissioning Team in Nottingham

The family of the victim were invited to meet with the Investigation Team but decided that they would prefer not to.

PAPER RECORDS:
The following documents were reviewed and/or referred to:
Clinical Records:

- S3ôs in-patient and community records held by Sheffield Care Trust
- S3ôs clinical records held by Capio Nightingale Low Secure Unit in Liverpool
- The records held by the Court Liaison and Diversion Service, including psychiatric reports provided to the Court prior to July 2004
- The Youth Offending Teamôs records.

Policies and Procedures:

- Al policies relating to the Care Programme Approach, Risk Assessment and the Mental Health Act had already been reviewed in the S1 and S2 Investigations.

APPENDIX 3

MINI BIOGRAPHIES FOR THE REVIEW TEAM

Maria Dineen – Director, Consequence UK Ltd
(RGN, RM, Bsc Hons, Capsticks Risk Management Diploma)

Maria is a Director of Consequence UK Ltd; she has an NHS background having worked as a nurse and a midwife between 1987 and 2004. In 2004 she took a career change within the NHS and moved into clinical risk management. She is recognised nationally for her work in the field and worked closely with the NPSA in their development of the NPSAôs RCA e-learning tool kit.

Maria leads training workshops for health and social care staff in the application of root cause analysis in adverse incident investigations. She also leads statutory and non-statutory independent investigations on behalf of Strategic Health Authorities in England, and independent health organisations.

Dr Mark Potter Consultant Psychiatrist and Head of Adult Services South West London and St Georges NHS Trust

Details of Current Post
Dr Potter leads a Community Health Team serving a population of 45,000 the catchment area served is an inner city area with significant pockets of deprivation. The service has a clear focus on serving the needs of the long term mentally ill. There are strong links with Social Services and Social Workers are fully integrated into the CMHT. As the Consultant Psychiatrist within the Team Dr Potter functions as the Clinical Team Leader. The responsibilities of the Clinical Team Leader include ensuring that the Team provides care which is safe, effective and efficient. These responsibilities also include ensuring clear accountability arrangements including supervision and appraisal for all staff within the team and being ultimately responsible for ensuring allocation of each individual Service Userôs care and directing the Teamôs overall resources accordingly.

Managerial Experience
1. Lead Clinician, Wandsworth Adult Service, May 1993 ï April 1996. This role involved close liaison with the Divisional Manager in the development of the Adult Service. Dr Potter was involved in the drafting of the Annual Business Plan and participated in contract negotiations and reviews with the purchasers. He also shared responsibility with the Divisional Manager for establishing and achieving the Key Performance Criteria for the Wandsworth Service. He took the lead in a number of significant developments during his time as Lead Clinician in particular the successful move from CMHT alignment by geographical area to GP Practice.

2. Clinical Lead, June 2000 to October 2001.
This role involved representing the Directorate at a Borough level in various forums. Dr Potter led on clinical issues at Borough level requiring negotiation, resolution or facilitation; he was also involved in the implementation of Directorate plans at Borough level. During his time as Clinical Lead key issues were the development and implementation of single management and the development of Clinical Governance within the Directorate.

3. Head of Psychiatry Adult Directorate October 2001 ï to date.
This role involves providing professional leadership to the medical staff within the Adult Directorate and advising the Clinical Directors on medical issues. Other responsibilities include overseeing appraisal for consultant staff and non-training grade doctors.

David Sharp – Health & Social Care Consultant, Associate Consequence UK Ltd

(Certificate of Qualification in Social Work, General Social Care Council Registered, Approved Social Worker, Certificate in Management Studies, Certificate of Credit in Professional Development ,)

David currently works as a Health and Social Care Consultant, specialising in the field of risk management and associated investigative work. He is an Associate of Maria Dineen and the organisation ñConsequenceò, a risk management and training consultancy to the healthcare sector in the UK.

David has worked in the field of mental heath in the West Yorkshire area, initially as a generic community social worker and then specialising in mental health. He became an Approved Social Worker with Kirklees Metropolitan Council (KMC). David was involved in the closure programme of a large psychiatric hospital, Storthes Hall in Huddersfield and the subsequent development of a range of integrated community services. He held senior management posts within KMC, Dewsbury NHS Trust (being responsible for CAMHS, Older Peopleôs Mental Health, Learning Disabilities and Adult Mental Health services) and latterly as a locality General Manger with South West Yorkshire NHS Mental Health Trust.

Prior to leaving the trust in 2004, he was Project Manger, for the implementation of a new Risk Management Strategy and assisting in the establishment of Root Cause Analysis organisational systems. Much of this work focused on risk culture issues.

David has been involved in a number of Root Cause Analysis investigations (in patient suicides within mental hospital and prison hospital settings) and has also been extensively involved in training on this topic across the UK through his work with Consequence.

He has in the past been involved in a variety of research projects (including research into ethnic sensitive services, continuing care needs, standards in mental health care and first episode psychosis, the latter with Birmingham University).In 1999 David visited Arrad in Romania as part of a Kirklees Social Services programme of support to the city and advised on substance abuse and mental health issues.

David has also undertaken work with the Northern Institute for Mental Health in England (NIMHE) and is an ñIndependent Personòin respect of responding to the complaints process within a northern local authority.

APPENDIX 4

GLOSSARY OF TERMS

Approved Social Worker:
The ASW role is a discrete one within a multidisciplinary context. The ASW service has built up considerable expertise in the correct implementation of the Act with local investment in developing and maintaining good working relationships with other agencies such as the police. The additional training and experience required to become an ASW acknowledges the responsibility of making assessments and reaching decisions in often stressful circumstances and of being a guardian of good practice in assessment (such as providing the least restrictive alternative for someone in acute mental distress).

An ASW has overall responsibility for co-ordinating an assessment under the Mental Health Act 1983. This service is available 24 hours a day, seven days a week and 365 days a year. Although warranted and appointed by an LA the ASW is personally liable for their actions. Following an assessment and in consultation with other professionals, families and carers, they make an independent decision ensuring that any intervention is the least restrictive necessary in the circumstances. The ASW provides a third party perspective, independent of the medical opinion, which is an essential part of maintaining the balance between liberty and safety required by current mental health legislation.

Care Delivery Concerns:
Where there are identified weaknesses, or failures, in the actual care and treatment that has been provided to a patient/Service User, either of commission or omission, these are termed Care Delivery Concerns.

Care Programme Approach:
The Care Programme Approach (CPA) was introduced in 1991 to provide a framework for effective mental health care. 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 Care Coordinator to keep in close touch with the service user and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care plan.

Clinical Governance:
Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence will flourish.

Community Mental Health Team:
When the Mental Health Implementation Guide was launched in March 2001, it declared:
ñCommunity Mental Health Teams, in some places known as Primary Care Liaison Teams, will continue to be the mainstay of the system. CMHTs have an important, indeed integral role to play in supporting service users and families in community settings.ò

Contributory Factors Framework:
This is a framework that enables one to explore and identify a broad range of influencing factors to any given problem. It is usually applied to complex problems and requires one to look at issues associated with:

- Team and social relationships such as team leadership and role congruence.
- Equipment design, maintenance, functionality and usage.
- Communication factors such as the delivery of verbal commands in terms of tone and the actual words used, and the clarity and legibility of written communications.
- Task design such as the detail contained within organisational policies and task guidance and the availability of decision making aids.
- Organisational culture and management, such as clarity regarding lines of accountability, the style of management, the presence of an open and fair culture or blame culture.
- Individual personal influences, such as ill health.
- Specific patient/Service User influences, such as their clinical presentation, long term illness, lack of compliance with treatment
- Training and education issues, such as the design, delivery and attendance at appropriate training events.
- Working environment issues such as heat, temperature, ratio of staff to patient and the skill mix of the staff.

HSG(94)27:
This is Department of Health Guidance on the discharge of mentally disordered people and their continuing care in the community. It contains specific guidance regarding the need for an investigation that is independent of the affected NHS health care provider when a person who is a patient of the mental health service commits or is involved in a violent incident, especially where another person is harmed.

Multi Agency Public Protection Arrangements (MAPPA):
This is a requirement of the Criminal and Court Services Act 2000 (amended in 2003) where Police, Probation, Local Authority and Health bodies have a statutory responsibility to supply and share information between agencies for the assessment and management of risks posed by violent and sexual offenders and other offenders who may cause serious harm to the public.

National Patient Safety Agency:
The NPSA is a Special Health Authority created in July 2001 to co-ordinate the efforts of the entire country to report, and more importantly to learn from mistakes and problems that affect patient safety.

Primary Care Trust:
A Health Service Trust that is responsible for the provision of primary healthcare services and the commissioning of secondary and specialist services within a geographical area.

Root Cause Analysis:
This is a structured and analytical approach to understanding the underlying features of significant care delivery, and service delivery problems identified in the analysis of a patientôs/Service Userôs care and treatment. A range of tools and techniques are available to help with this including the NPSAôs contributory factors framework, which was the tool used in this review.

Section 17 Leave:
Section 17 leave is a prescribed intervention under the Mental Health Act 1983, whereby a detained individual's Consultant Psychiatrist allocates leave as a fixed period of time, or on an indefinite basis up to the expiry date of the detention period, as part of an individual's treatment plan. The leave prescribed is only valid if the nurse in charge of the ward assesses the individual to be fit to use it when they want to leave the ward.
Section 17 Leave can be revoked in writing at any time by the patientôs consultant in the interests of the person's health or safety or for the protection of others.

Senior House Officer:
The Senior House Officer grade is the initial training grade for all doctors after full registration. It forms part of the continuum of medical postgraduate training, building on the experience and learning of the pre-registration year and preparing trainees for their next stage of training.

Service Delivery Concerns:
Where there are identified weaknesses or failures in the systems that should support, or underpin safe and effective care delivery, these are termed Service Delivery Concerns. Examples of Service Delivery Concerns are: A failure in management supervision, the design of a training programme which did not enable the core competencies expected of the staff to be achieved, the ónewô policy document was inappropriately implemented, and its impact on practice not assessed.

Timeline:
A timeline is a graphical, usually horizontal, map of the steps and stages in the patientôs/Service Userôs care pathway, including significant events in a patientôs/Service Userôs home or social circumstances. It enables the whole story to be reviewed in an easily digestible format, and triggers a broader range of questions about the care and management of the patient/ Service Users.