INDEPENDENT INVESTIGATION REPORT

REFERENCE SUI 2003/827 AND SUI 2004/282

Revised Investigation Report Issued Subsequent to the SHA Board Meeting on the 1st December 2006.
Date of Revised Report 31st December 2007.

This Independent Investigation was commissioned by the South Yorkshire Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance document HSG(94)27 and the replacement paragraphs issued in June 2005, requiring 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.

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
- Mr Jess Lievesley, Planning & Commissioning Manager (Working Age Mental Health), Hertfordshire Joint Commissioning Team.
- Dr Maureen Devlin, Independent Healthcare 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 the Service Users S1(2003/827) and S2 (2004/282) who are the subject of this report.

Note: This version of the report contains amendments made subsequent to the publication of the original report presented to the SHA Board on the 1st December 2006. These amendments were made following the opportunities presented to meet with S1's mother, a situation that was not possible to achieve during the original investigation.

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CHAPTER 1

BACKGROUND AND INTRODUCTION TO THE S1 S2 INVESTIGATION REPORT

1.0 BACKGROUND

Between 2003 and 2004 three Mental Health Service Users receive mental health services from Sheffield Care Trust (SCT) were involved in isolated incidents resulting in the death of three members of the public. Two of the Service Users (S1 and S2) were under the care of the Continuing Needs Service (CNS) and one Service User (S3) was under the care of the West Sector Service.[1] In the initial phase of commissioning an independent investigation into the care and management of the three Service Users it became apparent that in two of the cases there were a range of similarities in respect of;

- The same CNS was responsible for the management of Service User 1 and Service User 2.
- Difficulties were experienced in engaging Service User 1 and 2 with the mental health team.
- Service User 1 and Service User 2 both misused illicit substances.
- Service User 1 was from a mixed cultural heritage (Jamaican and Caucasian). Service User 2 was from the Somalian Community. Note:- The cultural background of each Service User per se was not an issue for the Investigation Team however an important component of the independent investigation was to establish whether issues of cultural unawareness on the part of the mental health service had any negative impact on the quality of care and service provided to either S1 or S2.

In view of the above listed similarities SYSHA commissioned Consequence UK Ltd to undertake a combined review of the care and management of S1 and S2.

Although the case of S3 was unsuitable for inclusion in the combined review, the SYSHA and Consequence UK agreed that S3's records would be analysed at the same time as those of S1 and S2 to enable the identification of any systems and processes common to all cases that needed to be explored.

Following an initial analysis of the Internal Investigation Reports of the Mental Health Service in Sheffield and the subsequent analysis of the Case Notes of S1 and S2 it was clear to the Investigation Team that the periods of care of most relevance to the subsequent incidents involving both Service Users were:

- January 2001 – 24 May 2003 for S1
- November 2002 – 2 February 2004 for S2

It is these periods therefore that the Investigation Team focused their attention on.

[1] Sheffield Care Trust has four Community Mental Health Teams (CMHT) serving specific sectors of the city. Each CMHT has a Sector Team and a Continuing Needs Service (CNS). The Sector Teams were responsible for Acute, Community and Primary Care Mental Health Services and the Continuing Needs Service was responsible for Rehabilitation, Recovery and Specialist Mental Health Services.

Note:- For contextual purposes the Outline Chronology for S1, detailed in the Annex (page 22), provides an overview of S1's contacts with the mental health services from January 1997 through to February 2001.

The outline chronology for January 2001 – May 2003 is presented on pages 25 – 29.

2.0 TERMS OF REFERENCE

The Terms of Reference for the Investigation
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 'named patient's' 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 patient's 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 Trust's Internal Investigations and whether the effectiveness of these interventions has been assessed.

3.0 INTENTION AND PURPOSE OF THE S1 AND S2 INVESTIGATIONS

This report sets out the Investigation Team's findings and recommendations following their analysis of the care and management of Patient S1 (S1) and Patient S2 (S2).

The period of care analysed for S1 was between January 2001 and May 2003. S1 was convicted of murder of his girlfriend on the 24th October 2003.

The period of care analysed for S2 was between November 2002 and February 2004. S2 was convicted of the murder of a near neighbour on the 23rd March 2005.

Purpose

The purpose of the investigation was to:

- Determine whether or not the care and management of both S1 and S2 was acceptable during the timeframes detailed above.
- Identify areas for improvement in the delivery of Mental Health Services to adults of working age in Sheffield.
- Determine the effectiveness of any improvements the Mental Health Service in Sheffield had already implemented at the time of this investigation.

4.0 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.[2]

The specific investigation and analysis tools utilised were:

- The Consequence UK Ltd structured Timeline.
- The NPSA's systems analysis framework.
- Thematic Analysis.
- A semi structured questionnaire, exploring key areas of concern identified across the care and management of S1, S2 and S3, issued to 60 staff members working across Adult Inpatient and Community Services in Sheffield Care Trust.

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

- S1 and S2's clinical records.
- Policies and procedures pertinent to the care and management of S1 and S2.
- Interviews with staff engaged in the care and management of S1 and S2.
- Interviews with a range of Managers at Sheffield Care Trust.
- Interviews with staff at the Somalian Mental Health Project, the Black Drugs Project and the Transcultural Team at Sheffield Care Trust.
- A meeting with Shelter Tenancy Support Agency and representatives of the Homeless Persons Team and the Anti Social Behaviour Unit.
- A meeting with the Family Liaison Officers assigned to the families of S1 and S2.
- The post-incident Forensic reports pertaining to S2.

Note: please see Appendix 1 for a full list of persons interviewed and documents reviewed during this investigation.

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

5.0 CONTACT WITH THE SERVICE USERS, THEIR FAMILIES AND THE FAMILIES OF THE VICTIMS

A request was made to both Service Users to give permission to the Investigation Team to access all records required in the undertaking of the investigation. Both Service Users gave their permission for this.

Subsequent to this the Investigation Team Lead invited both Service Users to advise it of any questions they would like incorporated into the investigation process. Permission was also sought to make contact with the families of the Service Users[3]. Although the correspondence was sent to each of the Service Users via their current Consultant Psychiatrist at the time no response to the Investigation Teams correspondence was received. Consequently the Investigation Team did not make contact with the family of either Service User. Towards the end of the investigation process and prior to the publication of the investigation report S1 and S2 were offered the opportunity to have sight of the Investigation Report and to go through it with a member of the Investigation Team. The permission of both Service Users was also sought to contact their family so that each family could meet with a member of the Investigation Team and have the opportunity to go through the report prior to publication. The letters to both Service Users were sent on the 31 October 2006. S1 declined the opportunity to have sight of the report and withheld his permission from the Investigation Team to make the report available to his mother. S2 and his sister met with the Investigation Team prior to the report's publication.

With respect to the families adversely affected by the actions of the Service Users (S1 and S2):

- Direct contact was made with the mother of the young woman S1 assaulted. She was advised that the Investigation Team had sought access to her daughter's records as part of the investigation.
- The family affected by the actions of S2 were approached via ISRAAC the Somalian Community Association as the most culturally appropriate contact route. No response was received from ISRAAC or the family.

[3] The Strategic Health Authority advised the Investigation Team Leader that a letter was sent to S1's mother at what they believed to be her address. However she had moved from this address in 1999. This communication was therefore unsuccessful.

CHAPTER 2

PATIENT S1
INVESTIGATION TEAMS FINDINGS

1.0 SUMMARY OVERVIEW – S1

Background

S1 is a young man of mixed race parentage (Jamaican and Caucasian). He has a long history of contact with the mental health services having had his first contact in 1993 at the age of 13 years.

Between this time and the incident in May 2003, S1 had five further inpatient episodes all of which, bar one, resulted in admission to either low or medium secure services as his level of aggression on the ward was difficult to contain. Each admission period lasted for a period of approximately six months.

The initial thoughts regarding S1's diagnosis was 'Drug Induced Psychosis'. This was subsequently changed to Schizophrenia with an eventual diagnosis of Bi-polar Affective Disorder with substance misuse.

With regard to his forensic history S1 had;

- one reprimand/caution for 'offences against the person' in 1998,
- one reprimand/caution for 'offences against property' in 1998,
- one conviction for 'offences against property' in December 2001,
- one conviction for public disorder offences in 2002,
- one conviction for offences relating to police/courts/prisons in February 2002.

After the incident of assault on his girlfriend, on the 21 May 2003, a previous girlfriend came forward and made a complaint against S1 regarding his treatment of her between the 6th and 8th of May 2002. In this complaint S1 was accused of assaulting his previous girlfriend and unlawfully imprisoning her.

July 2002 – May 2003

Following a marked deterioration in his mental health S1 was admitted informally to the Inpatient Ward in Sheffield on the 24th July. Subsequent to his admission S1 was sectioned under Section 3 of the Mental Health Act and he was transferred to a Medium Secure Hospital in Nottingham. He did not return to the Inpatient Ward in Sheffield until the 19th December.

S1 was discharged from Section 3 of the Mental Health Act on the 23rd January and subsequently took his own discharge on the 3rd February.

Following S1's return home his Care Coordinator tried to make contact with him every other week with variable success – this was a typical pattern of contact with S1. During this time S1's Care Coordinator was not aware that S1 had a new girlfriend and did not see him with a woman at any time.

The last face to face visit S1 had with his Care Coordinator prior to the incident was on the 8th May where his mental health state was noted to be 'OK'.

The Investigation Team is aware from the case summary compiled by the police between the 21st and 22nd May 2003 that S1's girlfriend had attended accident and emergency on Friday the 16th May at 23.18hrs with a head injury following a skull X-ray which showed no fracture she was discharged home.

The witness statement obtained from S1 also revealed that he had been living with his girlfriend for a number of months prior to the incident.

2.0 INVESTIGATION TEAMS FINDINGS S1

The Investigation Team's analysis of S1's clinical records revealed that S1 received a good standard of care from the Mental Health Services in Sheffield. Although S1's mother felt excluded from her son's care and management this was a result of S1 exercising his right as an adult to include or exclude family members from communications from, or communications with, his Care Team. However the records and the testimony of S1's Care Coordinator demonstrate appropriate care and concern for S1's mother. It is the opinion of the Investigation Team that S1's Care Coordinator made diligent efforts to provide an effective service to a young man who was not particularly willing to engage. With regards to communications with S1's mother the Investigation team does not believe that his Care Coordinator could have gone further in making positive contact with S1's mother without jeopardising the fragile therapeutic relationship he and S1 had. The chronology of S1's contacts with the service (section 4 page 19) highlight the challenges faced by the Mental Health Service Professionals in managing S1 and the reader is directed to this to achieve a full appreciation of the care provided to S1.

With regards to the Trust's own internal analysis of the care and management of S1, and his girlfriend, the Investigation Team found this to be of a good standard and displayed an appropriate degree of thoroughness and analytical thinking. It is important to note that the findings of this Investigation Team largely mirror the Trust's own reflections.

The Investigation Team highlight the following positive feedback:

- Throughout his contact with Mental Health Services S1 was appropriately transferred from Acute Adult Inpatient Services to more secure care environments when he was displaying behaviour that put himself and others at a level of risk that could not be managed in an 'open ward' environment.
- In February 2001 the Team Leader for the then North and West Continuing Needs Services proactively liaised with the South Yorkshire Housing Association to agree in principle funding from the Community Care Purchasing Panel so that S1's discharge from the Sheffield Low Secure Unit was achieved safely. .
- In recognition of the challenges and complexity S1 presented Co working was offered to his Care Coordinator in March 2001.
- The information exchange between the Medium Secure Service in Nottingham and the Acute Inpatient Service in Sheffield was excellent in 2002.
- S1 was assigned an appropriately experienced Care Coordinator from West CNS in May 2001. This individual had

substantive experience in assertive outreach work and had the necessary skills required to work with clients who were challenging to engage in treatment and regular contact with the community mental health service.

- S1's Care Coordinator appropriately challenged S1 in October 2001 when it transpired that he (S1) was having a relationship with a minor who was pregnant with his child. (It is this individual who brought the complaint of assault and false imprisonment in May 2002 against S1 in July 2003).
- In spite of the challenges of confidentiality S1's Care Coordinator between 25 May 2001 to the incident date tried to meet the needs of S1's mother without breaching his duty of confidentiality to S1 who did not want any information shared with her.

Potential Concerns

Initially the Investigation team had three main areas of concern regarding S1's care and management. These were:

- The circumstances surrounding his discharge from the Low Secure Unit on the 9th April 2001 and the non-availability of a Consultant Psychiatrist to take ongoing responsibility for him.
- His apparent discharge from Section 3 of the Mental Health Act on the 24th January 2003 without a mental health state assessment.
- The lack of knowledge within the Mental Health Service that S1 had not been to collect his prescription for approximately eight weeks prior to his deterioration and subsequent admission to hospital on the 24th July 2002.

Following a range of interviews and liaison with the mental health professionals via email and telephone, the Investigation Team established:

Potential Concern One: The circumstances surrounding his discharge from the Low Secure Unit on the 9th April 2001 and the non-availability of a Consultant Psychiatrist to take ongoing responsibility for him.

- On the 16th March 2001 a Mental Health Review Tribunal (MHART) sat at the request of S1. He no longer wished to stay in hospital. The outcome of the MHART was to order the discharge of S1 from the MHA. The application for a MHART had been made by S1 against the advice of his then Forensic Consultant Psychiatrist. Note: It is a detained patient's right to request a MHART. It cannot be denied regardless of the professional opinion of the professionals involved. Furthermore the decision of the MHART is binding even if the decision goes against the opinion of the health professionals caring for the patient.

- There was no representation at the MHART from S1's community team because his then Care Coordinator was on annual leave the day it was held. Although it is ideal if members of S1's care team could have been available there is limited scope for negotiating the date of the MHART to accommodate this. Furthermore once the date for the MHART is set there is generally little to no movement of the date allowed.
- The Consultant Psychiatrist who had agreed to take responsibility for S1 on discharge was a locum psychiatrist who was due to leave the employ of the Trust on or around the time of S1's discharge. (March/April 2001) This individual was not therefore able to attend the Section 117 meeting planned for the 27th March. Indeed there was no-one present at the Section 117 meeting who was going to be involved in S1's subsequent care. This situation it appears was largely unavoidable owing to annual leave, sudden sickness in one of the substantive Consultants to the West Sector CNS and the Locum Consultant Psychiatrist who was originally going to accept S1 on to his case load having left, or was about the leave the service.
- In view of the imminent departure of the Locum Consultant who had initially accepted responsibility for S1, S1's Forensic Consultant wrote to another consultant based in the North Sector[4] asking if she would accept responsibility for S1. This individual was unable to accommodate this request at such short notice owing to:
    - The emergency out-patient appointments being fully booked in the immediate future.
    - The sudden and unexpected sickness absence of the other substantive Consultant Psychiatrist working with West Sector CNS at the time. The remaining consultant was effectively covering the whole sector single handed at the time the request regarding S1 was made. It does appear that this Sector Consultant did suggest that she could accommodate a planned out-patient appointment at a later date but this offer was not accepted.
- A CPA Review meeting was held on the 25th May 2001 to hand over the care of S1 to the West Sector CNS. S1 was assigned to a Consultant Psychiatrist at this time who was present at the CPA meeting,
- Subsequently on the 25th June 2001a letter was sent from the Full Time West Sector Consultant to S1's Forensic Consultant

[4] While the forensic records say North Sector the unfolding chronology suggests that it was actually the West Sector.

advising that she believed that another Locum Consultant Psychiatrist had now taken over the care of S1.

Potential Concern Two: With respect to S1's discharge from Section 3 of the Mental Health Act on the 24th January 2003, without an identifiable mental health assessment, the Investigation Team established that:

- S1's Consultant Psychiatrist had good knowledge and understanding of S1 and had had a full discussion about him and his situation the day prior to discharging him from Section 3 of the Mental Health Act. S1's Consultant Psychiatrist feels that both he and the ward team had very good understanding of S1's mental state and that the decision they made was appropriate. This Consultant also advised the Investigation Team that even with the benefit of hindsight he would not have managed this situation differently. Although the documentation could have been better at the time of S1's discharge from Section 3 of the Mental Health Act the Investigation Team does not believe that the discharge was inappropriate.

Potential Concern Three: The lack of knowledge within the Mental Health Service that S1 had not been to collect his prescription for approximately eight weeks prior to his deterioration and subsequent admission to hospital on the 24th July 2002.

With respect to S1's non-compliance with medication this was a recognised risk and feature with him. How Mental Health Professionals become aware that a Service User is not taking their medications is achieved via a range of activities including;

- speaking with and questioning the Service User
- observing for signs of relapse
- liaising with the Service Users GP surgery
- speaking with a Service User's Carer or family if possible.

What does not appear to be established is any robust system for health centres and GP surgeries proactively alerting the relevant Mental Health Professional(s) if a patient is not collecting their medications. This is not unique to Sheffield however the issue is pertinent to Sheffield as issues of medication compliance and the absence of positive information sharing was also an issue in the care and management of S2.

Concern raised by the victim's family

In addition to the potential issues of concern identified by the Investigation Team the victim's mother was keen to understand how their daughter came to have a relationship with S1. It was their impression that the two had met whilst on the In-patient Unit. The Investigation Team were able to advise the family that their daughter was admitted to the In-patient Unit (8th February 2003) after S1 had taken his own discharge on the 3rd February 2003. Furthermore the

Trust's own internal investigation was not able to find any staff member who was aware of any relationship that either S1 or the young woman was having.

The Investigation Team's interview with S1's Care Coordinator in the community revealed that he was not aware that S1 was having a relationship with anyone. However he was rarely allowed into S1's flat and the face to face contact they had was often on the door step. Whilst this is not ideal S1's Care Coordinator would not have had the authority to insist on meeting S1 inside his home and it was appropriate for the Care Coordinator to accept S1's wishes in order to maintain face to face contact with him.

The victim's family told the Investigation Team that their daughter had 'moved in' with S1 shortly after her discharge home from hospital at the end of March. The young woman's mother shared that they had met S1 on a small number of occasions prior to their daughter moving in with him. On these occasions he had come across as a pleasant and polite young man. There was nothing that they could detect that suggested that their daughter was at risk as a result of the relationship.

Note 1:
The Investigation Team did review the clinical records of the young woman, and met her Consultant Psychiatrist at Interview. The contact this young lady had with the mental health service was very short and the incident occurred before the first Out Patient Appointment was held following discharge. The only thing that would have been different in her care and management today would have been referral to the Early Intervention Service (EIS) on discharge from hospital. This service was not available to the West Sector in 2003.

Early Intervention services provide specialist care for individuals who are in the early phase of psychosis using a team Assertive Outreach model of care, i.e. smaller caseloads and a model of care that tries to engage with the Service User in a way that is flexible to meet their needs. The service supports the notion that intervention at an early stage of a person's illness will promote optimum early symptomatic, social and personal recovery.

Note 2: It is important to note that although relationships between Service Users who are in-patients within Mental Health Services is discouraged, however, when relationships are established following discharge, or outside of NHS premises, as consenting adults there is little action NHS professionals can take except where there is sufficient information available to convincingly suggest that the life of one of the involved parties is at risk. Where there is no know serious risk to physical and psychological wellbeing and a relationship is known about, and considered inappropriate, it would be usual for a Mental Health Professional to advise the Service User of the concern. It is difficult to see what other actions are open to the Mental Health Professions.

Note 3: It is often the case that Service User's will not reveal to their family, Care Coordinator, or other professionals, information relating to personal relationships with other persons. In cases where relationships 'of concern' are known of by family members, and friends, of the Service User the Mental Health Services is reliant on communications between the family and the Mental Health Service professionals to alert them to the situation so that where possible appropriate action can be taken.

In the case of S1 his relationship with his girlfriend was known of by her family, as stated above.

S1's mother was also aware that her son had a girlfriend because he was generally happier than he had been. However she never met her son's girlfriend and therefore did not know what their relationship was like, or that her son's girlfriend had mental health needs of her own.

3.0 MAIN CONCLUSIONS S1

Following its analysis of S1's care and management by the Mental Health Service in Sheffield the Investigation Team do not believe that SCT should have managed S1 differently.

Specifically the Investigation Team found that:

- The care and management of S1 between 2001 and 2003 was reasonable and S1's Care Coordinator managed the fragile situation between S1 and his mother appropriately. The Investigation Team do not believe that the attack by S1 on his girlfriend was preventable by the Mental Health Service in Sheffield.
- S1's Care Coordinator (May 2001 – May 2003) employed an appropriate model of care in trying to effect the engagement of S1, and to maintain some degree of face to face contact with him.
- There were not any material changes in the care and management of S1 that could have been made that would have alerted the Mental Health Service to S1's relationship with his girlfriend. Consequently the Investigation Team do not believe that there was anything that could reasonably have been done to identify and thus reduce the risk presented by this situation. The Investigation Team is very satisfied that had the Mental Health Professionals been aware of S1's relationship with the young woman then they would have taken steps to warn her of the potential risk of violence to her person.

Annex

Outline Chronology of S1's contacts with the Mental Health Services in Sheffield

OUTLINE CHRONOLOGY OF S1'S CONTACTS WITH THE MENTAL HEALTH SERVICES PROVIDED BY SCT

Historical Background

Date	Event
December 1994	S1 was first referred to the mental health services in December 1994 at the age of 14 years. At this time the main issue appeared to be behavioural problems which commenced with the separation of his mother and father. The then Adolescent Service engaged with S1 and his mother to try and resolve these. S1 was eventually discharged from the Adolescent Service in June 1995 because of his unwillingness to meet with the service.
January 1997	S1 was subsequently re-referred (aged 16 years) following concerns raised by his mother regarding his 'increasingly antisocial behaviour'. S1 was offered an appointment at Oakwood Young People's Centre for the September of that year. The Consultant Psychiatrist also offered to arrange for a referral to the Adult Services ' in the hope of an earlier appointment'. S1 made no response to this correspondence and his case was therefore closed.
March 1997	S1 was assessed in the accident and emergency department of Northern General Hospital following his barricading himself in his bedroom after smoking a large quantity of Cannabis. The police attended at his home to break into his room and to deliver him to A&E.
1 April 1997	On the 1st April 1997, S1 (still aged 16 years) was admitted to the mental health unit under Section 2 of the Mental Health Act. His status was then regraded to Section 3 of the Mental Health Act. His main problem at this time was his excessive Cannabis use. The working diagnosis at this time was '?Drug Induced Psychosis' and '? Paranoid Schizophrenia'. S1 was discharged from this admission on the 2nd October 1997. At this time he was resistant to accepting assistance from the Mental Health Service and he was 'using dope' on a regular basis[5]. S1 was discharged to the then NE Sector Team.

[5] Source: Care Plan Record Sheet Case Notes Volume 2.

Historical Background

Date	Event
March 1998	S1 was admitted to Whitely Woods on an informal basis. His deteriorating mental health state was highlighted by S1's refusal to accept treatment for a broken bone in his hand. There was a second episode of treatment refusal at the end of March following lacerations to his arm.
1 April 1998	S1's status at Whitely Woods was changed from informal to a formal detention under Section 2 of the Mental Health Act. This was subsequently altered to Section 3 of the Mental Health Act on the 30 April.
30 April 1998	S1 was discharged from Section 3 of the Mental Health Act and remained as an inpatient on an informal basis. His mother's testimony reveals that at this time the mental health professionals believed that S1's problems were predominantly substance misuse related and also stemmed from family difficulties. S1's mother was very dissatisfied with the approach of S1's then Consultant Psychiatrist. She was provided with details of a substance misuse clinic in London.
June 1998	S1's mother sought a second opinion regarding her sons' diagnosis. On the 25th June a diagnosis of Schizophrenia was given by the 2nd opinion doctor.
July 1998	S1 discharged himself from in-patient services back to his flat.
March 1999	S1 (now 18 years) was admitted to hospital under Section 2 of the Mental Health Act (1983) in March 1999. His presenting features on this occasion were; ❑ disruption at college ❑ paranoid beliefs including religious beliefs "I am one of the crew close to God" ❑ feeling unsafe in the community. At this stage S1 was keeping a knife tied to a stick in his bedroom in case any one tried to burgle the house. S1 had, as far as SCT staff were aware, never been charged with any offence, and had at this stage never 'come face to face with the law'. In fact S1 had been cautioned on two occasions in 1998. His forensic history is noted in his clinical records to be: ❑ smashing windows ❑ stolen property ❑ Disturbing the peace At this stage he was denying the use of drugs or alcohol.

Historical Background

Date	Event
9 April 1999	On the 9th April, S1 was admitted to The Spinney[6] as a result of violent and disturbed behaviour on the open ward at Northern General Hospital. S1 did not harm anyone but did cause damage to property and made verbal threats towards the staff. During his admission to The Spinney S1 was diagnosed with Schizophrenia, with substance misuse.
November 1999	S1 was discharged from The Spinney following a Mental Health Review Tribunal on the 1st November 1999. The clinical records suggest that S1 was discharged as homeless because he would not stay as an informal patient whilst the staff at The Spinney organised supported accommodation for him and he refused to reside at his mother's. This is at odds with the recollection of his mother who clearly recalls picking him up from an office in Sheffield. She is quite certain that her son then lived with her until Christmas before leaving home. He was then provided with a flat at Lowedges.
24 June 2000	S1 was admitted informally to Maple Ward as a 'Rowan Outlier'. S1 wanted to 'find a medication that suited him and to calm him'. A preoccupation with religious thoughts remained along with paranoid ideation. He remained inconsistent with his medication (Zotepine). Continued to take Cannabis regularly. S1 took his own discharge against medical advice on the 6th July 2000.
10 July 2000	S1 was informally readmitted to Maple ward. On the 24th July he was detained under Section 3 of the MHA. This was S1's sixth admission since 1996. A request was made for S1 to be referred to The Spinney on the 27th July 2000 because he had become violent to patients and staff. At a tribunal on the 16th October a decision was made not to discharge S1 and consequently arrangements were made for his transfer from The Spinney to Forest Lodge on the 27th October by his then Consultant Psychiatrist.
February 2001	S1 was admitted to Forest Lodge (Low Secure Unit) and discharged on 9th April 2001. His diagnosis was noted to be Bipolar Affective Disease – currently in remission (F37.7). S1 had been transferred to Forest Lodge from the Spinney as part of his rehabilitation. S1 remained a detained patient under the MHA at this time. S1 is noted to have settled quickly into Forest Lodge and after a period of two weeks was transferred from the Acute Admissions Ward to the Rehabilitation Wing where he had 1-1 sessions with nursing staff addressing issues of substance misuse and the impact of Cannabis on his mental state. He was

[6] The Spinney is a private medium secure facility

encouraged to attend the Rockingham Drug Centre but showed little interest in this. No psychotic symptoms were observed while he was at Forest Lodge. He did display verbal outbursts but the records show that he was able to contain this with minimal nursing input.

Chronology March 2001 – May 2003

Date (all 2001)	**Event**
April	At a Mental Health Review Tribunal on the 16th March 2001, S1 was given a Deferred Discharge from Section 3 of the MHA effective from 2nd April 2001.The clinicians requested time to coordinate his discharge from hospital but S1 left the hospital before all necessary arrangements could be made. At the time of his leaving there was no definite decision as to who would be his Consultant Psychiatrist or community nurse. S1 did however have a Care Coordinator. S1's Consultant Forensic Psychiatrist was temporarily holding Consultant responsibility for S1 until the issues could be addressed. Because of S1's sudden discharge the Team Manager for CNS North Team organised placement funding in principle from the Community Care Purchasing Panel so that S1's immediate discharge was safe – he was discharged to a sheltered housing project (911). Co-working was also offered to S1's Care Coordinator in view of the complexity of S1's needs. The Care Coordinator worked for the Transcultural Team (TCT) at this time and had a city wide remit.
23 March	A letter is received by the CMHT Consultant from S1's Forensic Consultant asking her to take over S1's care and management.
25 June	The CMHT Consultant writes to the Forensic Consultant advising him that a Locum Consultant had taken over the care and responsibility of S1.
8 November	S1 does not attend for his outpatient's appointment.

Chronology March 2001 – May 2003

Date (all 2002)	Event
16 June	S1 has his first appointment with his substantive Consultant Psychiatrist.
24 July	S1 believes he is unsafe as he felt some people were trying to kill him (note these thoughts may have had some basis in reality as he had assaulted his girlfriend and there was a genuine risk of repercussion from this). S1 has an Informal admission to Maple Ward, following assessment by his Care Coordinator and a Consultant Psychiatrist.
2 August	S1 was involved in a fight with another patient. This patient suffered a black eye and the windows in the entrance door to the ward were broken. As a result S1 was taken to the Police Station, charged and placed on Section 3 of the MHA and transferred to the Intensive Treatment Service. In addition to the incident of assault S1 had been generally deteriorating prior to this, was not medication compliant and required containment in a low stimulus environment due to the increase in his assaultative behaviour. **Note:** At this time it is reported that the In-patient Ward was undergoing a period where it had a high number of young and boisterous patients with high expressed emotions. This situation made it difficult for S1 to settle. Following his transfer to ITS S1 became more unsettled (10th and 11th August). A decision was made on the 12th August to continue with S1 on ITS to try and control his symptoms. S1's behaviours continued to escalate culminating with an assault on a staff member who required six sutures to the head. ITS was therefore not seen as an appropriate environment for S1. Following assessment at Forest Lodge on the 13th August a decision was made to transfer him to a medium secure unit.

Chronology March 2001 – May 2003

Date (all 2002)	Event
2 August cont..	Medication at this time: 15mg Olanzapine at night and lithium 1,200mg at night. PRN Lorazepam up to 4mg in 24hours and PRN Diazepam 5mg up to 20mg in 24 hours. PRN Chlorpromazine 25mg – 50mg up to a maximum of 400mg in 24 hours.
15 August – 18 Dec	S1 was a patient at Wathwood Medium Secure Hospital.
19 December	S1 was discharged from Wathwood back to the In-patient Ward in Sheffield. It was noted in his discharge summary from Wathwood that staff on Maple Ward may wish to review S1's medications to see if he could be managed on lower doses. On re-admission to the In-patient Ward S1 appeared to be over sedated to the staff and was difficult to motivate.
26 December	S1 went to his mother's for Boxing Day. The mother of his child was also at the home of S1's mother that day. S1's mother recalls that he was fine with his previous girlfriend, a little shy of his daughter and keen to get back to the Northern General Hospital on time.

Date (all 2003)	Event
15 January	S1 is still experiencing pressure of speech, losing his temper and still claims to be a messenger of God.
16 January	S1 feels that he is over sedated. He is also expressing concerns about his ground floor flat as he has 'a tendency to get into trouble'. S1 makes clear that he does not want his mother involved in his treatment. He also tells staff that he has 'a lot of religious beliefs that are different from other people. He is apparently afraid to discuss these as he would end up in hospital. Action: For Care Coordinator to look at improved security for S1. This day was also the date of S1's CPA Review.

Chronology March 2001 – May 2003

Date (all 2003)	Event
22 January	MDT Ward Round with S1's Consultant Psychiatrist: S1 continues to express reservations about his flat because of fears of being 'pursued by people who may be after him'. Again it is noted that these are legitimate fears. There is a general agreement amongst staff present that it would be appropriate for S1 to be re-graded to informal and a decision is made for his Consultant Psychiatrist to review S1 the following day (23rd January) with a view to enacting this.
23 January	S1 is visited by his Consultant Psychiatrist at 16.30hrs. S1 is asleep. The notes record that S1's Consultant Psychiatrist 'will take him off his section, it expires next week anyway (1/02/03)'.
29 January	MDT Ward Round with S1's Consultant Psychiatrist The records note that S1's Lithium levels were done on the 20 January and were 0.7mmol. The notes also note that S1's Consultant Psychiatrist felt that the Olanzapine levels could be tapered prior to discharge.
3 February	S1 was reviewed again and told staff that he wanted to discharge himself. He did not admit to any symptoms and said he was sleeping for approximately 12 hours a night. The records note that he is feeling well and that he has plans for the future. S1 is noted as saying that he will take his medication and that he is happier with the medications he is on. These are: Lithium 1200mg at night Olanzapine 20mg twice a day. Warning signs of relapse are noted as discussed with S1. S1 is also noted to express trust in his Care Coordinator and that this individual would alert him to any signs of relapse. S1's mother was present on this day and recalls staff shaking her son's hand and wishing him well. It is her recollection that his desire for discharge was expected and welcomed. S1's mother took S1 to his flat in Mount Street following his discharge.
5 February	S1's Care Coordinator visits S1 at home as agreed but he could get no answer and S1 did not appear to be in.
11 February	The Care Coordinator notes state "S1 appears to have slipped back into his previous behaviour, i.e. always being in bed when I visit and asking me if I can call back another time. He did however appear friendly and relaxed."
17 February	Telephone contact with S1

Chronology March 2001 – May 2003

Date (all 2003)	Event
3 March	Attempted Home Visit – no access
5 March	Telephone contact regarding S1's Disability Living Allowance (DLA). It transpires that S1 needs to make a fresh claim.
12 March	Home Visit. Records say "as usual S1 had just got up despite this being in the afternoon". S1's Care Coordinator had taken the DLA forms with him but S1 was not interested in filling it out. The records also note that S1's 'mental health appeared OK'.
19 March	Home Visit. The Care Coordinator records state that S1 'appeared well'. The record also notes that S1 was on his way to pick up his prescription and that he had not received his DLA form.
21 March	S1 did not attend for his Out Patient's Appointment. The subsequent letter to S1's GP highlights that his Consultant Psychiatrist feels that 'it is quite important to keep an eye on him because he is somewhat alienated'. The Consultant also requested that the GP advised him if S1 does not collect his prescriptions or if he suspects he is not taking his Lithium.
27 March	Home visit. The records note that S1 appeared well and that S1 had signed his DLA forms. The next contact looks to have been in early April when S1 contacted his Care Coordinator to arrange an appointment. There is then a gap in visits made to S1 that are not fully explained. We do know that S1's Care Coordinator had approximately eight days leave during the month of April and that there was a 'Team Away Day' that he attended. Over and above this his Care Coordinator cannot recall why he did not see S1 over this four week period.
8 May	S1 contacted his Care Coordinator to make an appointment. A home visit was made on the same day. S1 did not want his Care Coordinator to come into his flat. The meeting therefore took place on his doorstep. At this time S1 advised that he had missed an out patient's appointment and asked his Care Coordinator if he would organise another for him. The record notes that 'his mental health was OK.'
21 May	The next record is that S1 had been arrested on a serious charge.

CHAPTER THREE

PATIENT S2
INVESTIGATION TEAMS FINDINGS

1.0 SUMMARY OVERVIEW S2

S2 is a Somalian gentleman who immigrated to the United Kingdom in 1998. Initially S2 lived in London, moving to Sheffield in 1994 and eventually settling in Sheffield in 1996. S2 is reputed to have been a well liked and respected member of the Somalian Community when he first moved to Sheffield. He initially worked for the Isak Somali Community as a volunteer and then the Citizen's Advice Bureau between 1998 and 1999. [7]
The general impression gleaned by the Investigation Team was that S2 was an intelligent man of good social standing within the Somali Community who spoke fluent English.

With regard to his forensic history S2 had three convictions prior to his contact with the Mental Health Service in Sheffield;

- failure to surrender to custody (October 2001),
- failure to provide a specimen for analysis and failure to surrender to custody (December 2001),
- drunk and disorderly and failure to surrender to custody (October 2002).

Inpatient Episode
On the 11th November 2002 S2 was admitted under Section 2 of the Mental Health Act (MHA) for assessment and treatment following violent and aggressive outbursts in his flat where he had smashed the windows and the TV. S2 had also tried to burn down the door of his brother's flat causing fire damage to the lock and insulation of the door. In addition to his violent outbursts S2 was experiencing significant thought disorder, including voices telling him to do things such as 'to burn the house down'. S2 also made claims that he was able to communicate with the television and that Sky Television was able to broadcast into people's minds via lights and infrared radiation[8].

S2's period of detention on the Acute Admissions Ward was punctuated by frequent episodes of 'absent without leave' (AWOL) behaviour, and a number of violent outbursts including smashing his way out of the ward into the garden with a Fire Extinguisher on the 27th November (2002) when he was told that he could not 'take leave' because of the need to assess him.[9]

S2 was regraded to informal when his section lapsed on the 6th December 2002. He was subsequently discharged into the care of the West Continuing Needs Service on the 7th March 2003.

[7] Source: Confidential Psychiatric Report Prepared for Review Tribunal 29 November 2005.
[8] Source: Clinical records S2 and Confidential Psychiatric Report Prepared for Review Tribunal. 29 November 2005
[9] There were 12 recorded episodes of AWOL between the 14th November 2002 and the 3rd January 2003.

Community Care

Following his discharge into the community S2, following an initial concern regarding his mental state raised by his Support Worker at the Shelter Tenancy Support Agency, remained relatively settled. He did not however display any willingness to engage with his Care Coordinator or any of the opportunities offered by the statutory or non-statutory services made available to him. The analysis of S2's clinical records showed little successful face to face contact between S2 and his Care Coordinator in the five months preceding the incident date. A pattern of 'no access' at attempted home visits and numerous unsuccessful attempts to make contact with S2 by telephone dominate.

In December 2003 there was a marked deterioration in S2's behaviours which, in many respects, replicated those leading to his initial admission in November 2002. In brief the following represent key events in the last two months leading to the attack on the victim's home:

- 2nd December (2003). S2 was described as "extremely paranoid and suspicious" by his Care Coordinator in the clinical records. At this home visit S2 threatened to target a Somalian Police Officer in London, and told his Care Coordinator that he loved her and wanted to kiss her.
- 7th January (2004). The warrant office confirms that there is a warrant out for S2's arrest following damage to property.
- 13th January (2004). S2's flat is noted to be unsecured with TV on, but with no reply.
- 14th January (2004). A housing officer contacts S2's Care Coordinator. They are outside S2's flat which is causing a noise disturbance. There is no evidence of S2 being in residence.
- 19th January (2004). A Housing Officer notifies S2's Care Coordinator that S2's neighbours are complaining about loud music throughout the night, loud TV and smashed window.
- 19th January (2004), S2 is assessed by the Court Liaison and Diversion Mental Health Team. No evidence of psychosis or mental illness elicited.
- 22nd January (2004). S2's Care Coordinator was informed by the Housing Officer that S2's neighbours have been complaining about music being played all night for the last week.
- 23rd January (2004). S2 attends Howden House to take responsibility for the damage to the window of his flat. He tells the Housing Officer that he loves her.
- 26th January (2004). S2 makes two unprovoked attacks on a Somalian Gentleman (the husband and father to the victims) in front of a Housing Officer. (Note this attack is recorded as

having occurred on the 30th January in S2's Care Coordinator records). S2 was taken into custody following this event and assessed by a Police Surgeon.[10]

- An enquiry to one of the Inpatient Wards by the Police Surgeon resulted in a response that no computerised record could be located though details of S2's care and treatment were available on INSIGHT.[11]
- 30th January (2004). S2's Care Coordinator accompanied by a colleague attempted a home visit to assess S2. All windows are boarded up except one above the front door which was smashed. On a previous letter sent to S2 by his Care Coordinator were the words "every last drop of blood is political".

On the 2nd February 2004 S2 attacked the home of a fellow Somalian by arson. In this attack a child was seriously injured and its mother lost her life.

[10] Source: Witness statement made by the Forensic Medical Examiner, (and General Practioner) for South Yorkshire Police on the 2nd March 2004)

[11] INSIGHT is the electronic care planning and Care Programme Approach package in use within SCT. Its purpose is to enable the Mental Health Care Professionals to have access to up to date information about a Mental Health Service User so that appropriate care and treatment can be provided.

2.0 INVESTIGATION TEAMS FINDINGS S2

A full analysis of S2's care and management as provided by the Mental Health Services in Sheffield was undertaken. There were a number of aspects of S2's care and management that gave cause for concern, these are detailed in chapter 3.0 (pages 34-60) of this section of the report. There were also features of S2's care and management that require positive feedback and this is detailed below at 2.1.

2.1 Positive Feedback

The following details the identified good practice that requires recognition within the context of this report:

- The initial admission history taken from S2 by the duty SHO in A&E on the 11th November 2002 is thorough and comprehensive. It provides a detailed account of S2's delusional beliefs at the time of his admission and notes his threat to burn down his brother's house.
- Following a direct threat by S2 on the 26th November 2002 to 'set fire to the housing complex where he lived prior to admission' his named nurse instigated the missing person procedure, reporting S2 as a 'Category A' patient[12] when he went missing at 19.00hrs the same evening. The Manager of the Housing Project had been informed about the threat earlier in the day and efforts were made to contact the project when S2 went AWOL.
- S2's Care Coordinator was instrumental in negotiating a delayed discharge, of some six weeks, with his Consultant Psychiatrist and the Ward Manager so that a Tenancy could be organised and S2 not discharged from hospital as homeless. To have discharged S2 as homeless would not have been in his best interests.
- Although S2's Care Coordinator did struggle to effect a therapeutic relationship with him, her clinical records and information shared with the Investigation Team at interview demonstrate that she was diligent in her efforts to provide support to him. An example of this is, on the 17th November 2003 she made contact with the Immigration and Nationality Directorate in Sheffield to provide confirmation regarding S2's situation and to request on his behalf a British Passport so that he could visit his mother in Somalia.
- It was evident from the clinical records and discussions with S2's Care Coordinator, that she made stringent efforts to seek the advice of senior colleagues in the management of S2

[12] When a patient goes missing from an inpatient ward a missing person's procedure is activated. If the patient is not located within the grounds of the Mental Health Service they are reported as missing to the police. Depending upon the risk the person poses to themselves or to others determines the category (ABC) assigned. Category A indicates a high risk person.

between December 2003 and February 2004. This individual quite clearly recognised her own lack of experience in working with clients such as S2 and in evoking an assessment under the Mental Health Act.

- The Tenancy Support Worker at Shelter showed consistent diligence and concern for his client, S2, that resulted in some degree of engagement with Shelter, albeit tenuous.
- In spite of the challenges faced by the Team Leader for the Continuing Needs Service responsible for S2[13], S2's Care Coordinator received a considerable degree of support and supervision from the Team Leader throughout her contact with S2.
- In December 2003, following a clinical disagreement between S2's Care Coordinator and his Consultant Psychiatrist on the 5th December the Team Leader undertook to accompany S2's Care Coordinator on a home visit on the 19th December so that he could assess S2's mental state for himself.

2.2 Principal Care Delivery and Service Delivery Concerns

The analysis of S2's care and management between the 11th November 2003 and the 2nd February 2004 revealed a range of concerns that the Investigation Team believes contributed to the inability of his Care Coordinator, Consultant Psychiatrist and the West CNS to effect engagement of S2 with the Mental Health Services. Furthermore the Investigation Team believes that these concerns also contributed to the staffs' lack of appreciation of the seriousness of S2's deterioration between the 2nd December 2003 and 2nd February 2004.

The principal concerns identified were:

1. The period of time S2 was detained under Section 2 of the Mental Health on an in-patient ward in Sheffield did not result in an effective assessment of his mental health state and consequently there was uncertainty and ambivalence regarding his diagnosis.
2. S2 was not actively engaged in the management of his mental health needs following his discharge to the Continuing Needs Service in March 2003. This situation prevailed until his arrest on the 2 February 2004 following the incident of arson.
3. Between December 2003 and February 2004 there were two occasions where S2 should have had his Mental Health State assessed with a view to offering him an informal admission or detention under the Mental Health Act. Although S2's Care Coordinator and other team members were engaged in

[13] At the time S2 was receiving care from Sheffield Care Trust the Team Manager held leadership and management responsibility for the CNS in the West and the Homeless Assessment and Support Team. This situation of managing two teams across two sites provided challenges in the provision of regular monthly supervision to all of the 19 staff he was responsible for.

discussions regarding what action to take and the appropriateness of a MHA Assessment on neither occasion was such an assessment initiated.

2.3 The most significant influencing factors to the above stated concerns

Following an analysis of the information gathered during the investigation process the Investigation Team agreed that the following factors were of most significance in enabling the above stated concerns to prevail:

The Ineffective Assessment of S2 whilst an in-patient:

- The lack of an agreed and clearly documented plan of management for S2 whilst he was an in-patient.
- The lack of containment of S2 during the period of his detention.

The lack of engagement by and of S2:

- There was an ineffective harnessing of the collective knowledge and experience of services that may have been able to facilitate the opportunity for increased engagement with the Mental Health Service by S2. (The lack of CPA Review was a factor here).
- The Care Coordinator assigned to S2 had little insight into the Somalian Culture, including the culturally established social habit of chewing Khat[14].
- The Team Manager for the West CNS made a decision not to change S2's Care Coordinator in December 2003. At this time the Team Manager was aware;
    - that a male worker might achieve better engagement with S2 (none was available to take the Care Coordination role when S2 was discharged into the community in March 2003),
    - that S2's current Care Coordinator had had a number of periods of sickness absence.

  These were both issues that the Team Leader initially felt were good indicators for effecting a change in Care Coordinator. However after a period of reflection and in view of the signs of relapse in S2, the Team Leader believed it would be better for S2 if stability in Care Coordinator was

[14] Khat is a green-leafed shrub that has been chewed for centuries by people who live in the Horn of Africa and Arabian Peninsula. It is a stimulant drug with effects similar to amphetamine; Khat users therefore describe feeling more alert and talkative. Regular use however may lead to insomnia, anorexia and anxiety. Psychological dependence can result from regular use so that users feel depressed and low unless they keep taking it. The plant leaves only remain potent for a few days after it is picked.

Reference:http://www.drugscope.org.uk/druginfo/drugsearch/ds_results.asp?file=%5Cwip%5C11%5C1%5C1%5Ckhat.html

maintained. It is the impression of the Investigation Team that the inability of S2's Care Coordinator to engage with him was not seen as the dominant factor in this decision making process.

- Notwithstanding the above S2 himself demonstrated a consistent lack of interest in any of the services made available to him regardless of whether these were offered by the statutory or non-statutory sectors. From the information shared with the Investigation Team it is unlikely that S2 would have engaged with the Mental Health Service offered in Sheffield whatever the West Continuing Needs Service did to try and engage him.

The lack of assessment of S2 by his Consultant Psychiatrist and the lack of MHA Assessment in the last week in January 2004:

- There was (and remains) a lack of structured process for Care Coordinators to escalate concerns about the care and management of the Service User for whom they carry Care Coordinator responsibility where significant disputes arise regarding the management plan and local resolution measures fail to achieve a satisfactory outcome.
- The West CNS did not correlate S2's initial presentation to the Mental Health Services with the behaviours he was displaying between 2nd December 2003 and 30th January 2004. This, along with a variable presentation, led to an overemphasis on S2's substance misuse issues and a lack of consideration of the psychotic features of his presentation.
- On Monday 26th January 2004 S2 was observed to attack an apparent passer-by outside his (S2's) flat. This attack was witnessed by a Housing Worker at the Central Housing Department and the 'Repair Man' who had accompanied her to effect the securing of S2's residence. The information about the attack was not successfully communicated to the West CNS until Friday 30th January 2004.

- The information about this attack was also known to the local police. S2 was assessed by a Police Surgeon on the evening of the 26th January and was released on bail. There was an incident of mis-information between the Police Surgeon and the Mental Health Service when he (the Police Surgeon) asked for details regarding S2's mental health. He was informed that S2 was 'not on the computer'. However the local police force were aware that S2 was known to Mental Health Services. Unfortunately there does not appear to be an established communication pathway for Care Coordinators to be advised when a Service User is arrested. (Note: Owing to the passage of time this factor was not explored with staff as the Investigation Team considered it unreasonable to expect staff members to remember an evening telephone call some two-and-a-half years previously).

3.0 CONTRIBUTORY FACTORS: SYSTEMS ANALYSIS OF THE SPECIFIC CARE DELIVERY AND SERVICE DELIVERY CONCERNS IDENTIFIED DURING THE ANALYSIS OF S2'S CARE AND MANAGEMENT

In keeping with the principles espoused by the NPSA in its national RCA training programme, the key concerns identified during this investigation have been analysed using its systems analysis framework as a guide.

The following pages set out the Investigation Team's understanding of the contributory factors to the stated concerns and issues detailed in Chapter 3, Section 2.3 page 33 of this report.

1. S2 was not actively engaged in the management of his mental health needs while a client of the South West Continuous Needs Service

Non-engagement with the statutory and non-statutory Mental Health and Substance Misuse Services was a constant theme from the time of S2's initial contact with the Mental Health Service in Sheffield in November 2002, to the day of the incident on the 2nd February 2004. In view of the incident that S2 was involved in, it was essential that the Investigation Team achieved a good understanding of the reasons for this lack of engagement by S2. The following presents the Investigation Team's understanding of the complex range of factors that seemed to have contributed to this, the most significant of which the Investigation Team are agreed as:

1. **The ineffective harnessing of the collective knowledge and experience of services that may have been able to facilitate the opportunity for increased engagement by S2 with the Mental Health Service, or other services, by the West Continuing Needs Service.**

Comment:
It is clear from the analysis of S2's clinical records and information shared at interviews with The Black Drugs Project, Shelter Central Tenancy Support, The Somali Mental Health Project (SMHP)[15] and S2's Care Coordinator that concerted efforts were made by S2's Care Coordinator, Shelter and The Black Drugs Project to engage S2.
S2's records detail numerous correspondences between;

- Shelter and S2,
- S2's Care Coordinator and S2,

and a number of telephone messages;

- from The Black Drugs Project to S2's Care Coordinator updating her regarding S2,
- between S2's Care Coordinator and the worker at Shelter Central Tenancy Support.

The common thread through all of these contacts is the lack of response by S2.

With respect to the SMHP the notes revealed considerably less information regarding contact between this service and S2's Care Coordinator. S2's Care Coordinator, it transpires was working under the belief that the SMHP had assigned a named worker to S2. On the 14th May 2003, approximately two

[15] The Somali Mental Health Team to which the CPA document referred was actually the Somali Mental Health Project. This is a non-statutory agency which has a wide remit, one of which is to support the engagement of members of the Somali Community with the statutory mental health services where appropriate. The Projects members do not provide a formalised mental health service but work in partnership with the mainstream services. For the Somali Mental Health Project to become engaged with a mental health service user from their community the person has to actively agree to this. If there is no agreement from the community member then the Somali Mental Health Project cannot become involved other than to provide the mental health worker with objective advice on the customs and beliefs of the Somalian Community and to provide a sounding board on how one might go about engaging a community member.

months after S2's discharge from the in-patient unit, this individual wrote to the person she believed to be the SMHP Worker asking for an update on progress made with S2. No formal response was received to this communication. The Project Manager at SMHP told the Investigation Team that he believed a number of attempts were made to contact S2's Care Coordinator by phone but that these attempts were unsuccessful. The lead mental health worker at SMHP also told the Investigation Team that the first time he was aware of correspondence to the project from S2's Care Coordinator was when the Investigation Team highlighted its existence.

What was not appreciated by S2's Care Coordinator, or any professional present at S2's Discharge CPA on the 16th January 2003, was that the SMHP can only become actively involved in supporting the delivery of mental health care to one of its community members if they (ie in this case S2) give their express permission for this. S2 never consented to the SMHP having any level of input into the delivery of his mental health care plan. Consequently SMHP could not provide any level of support to him.

It is laudable that S2's Care Coordinator did try to effect support for S2 via a range of different organisations and did demonstrate a willingness and ability to work in partnership with Shelter Central Tenancy Support, in particular but, she did not make use of a specialist service available to her within SCT. This service was the Transcultural Team (TCT). The aims of this service are;

- to undertake joint assessments with the range of community based teams within SCT on any new client to the Mental Health Service where there may be cultural aspects that the named Care Coordinator may not have the knowledge to manage/deal with,
- to work alongside an Enhanced CPA Service Users Care Coordinator to provide culturally appropriate support. The Transcultural Team cannot assume Care Coordination responsibility as a number of its team have yet to attain the level of professional qualification to enable this to happen,
- to provide support to the Care Coordinators of Service Users on Standard CPA on an as-needed basis where there are difficulties in engaging the Service User and these are thought to be culturally related.

S2's Care Coordinator told the Investigation Team that whilst she was aware of the Transcultural Team no approach was made to them because she believed that the engagement of the Somalian Mental Health Project (SMHP) was sufficient. Furthermore it does appear that engagement of the TCT is sporadic within the Trust, with a number of staff the Investigation Team interviewed not having a clear idea of the remit of this team[16]. S2's Care Coordinator also told the Investigation Team that the CNS she was working with were one of the least pro-active in engaging with the TCT during the time she was working with S2. It would appear from interviews with TCT staff that one of the reasons for this is that other sectors of Sheffield had a higher

[16] The questionnaire issued to staff did not reflect the impression the Investigation Team gained during the interviews held. Most staff responding to the questionnaire provided appropriate information about the TCT and said that they found it to be a valuable service,

proportion of Black and Minority Ethnic (BME) clients at the time. The West Sector has a predominantly Somali and Yemeni BME population and it is only in recent times that a Yemeni Worker has joined the TCT. TCT did have a Somalian Worker at the time S2 was engaged with the Mental Health Service in Sheffield.

Had S2's Care Coordinator made contact with the TCT the Somalian Worker would have been able to provide support to her in;

- understanding the cultural context for S2
- liaising with S2's family
- undertaking joint or solo visits to see S2.

Unlike the SMHP the TCT is not reliant on the Service Users express consent to become involved. It is the experience of the TCT that even where a Service User says that they do not want contact with a TCT Worker from their own community this initial reticence is frequently overcome following first contact between TCT and the Service User or their family. At minimum the TCT can provide 'behind the scenes' support where engagement with the family or Service User is not possible.

In addition to the non-use of the TCT there were no opportunities provided for the range of services trying to engage with S2 to come together to discuss how they might work more effectively to achieve this. The CPA meetings, post S2's discharge from the in-patient ward in March 2003, should have provided an opportunity for this. Unfortunately S2's Care Coordinator was on sick leave for the planned CPA meeting on the 12th June 2003 and this meeting did not therefore take place.

Subsequent to S2's Care Coordinator returning to work in July 2003 a CPA meeting was initially planned to take place in December 2003, this was deferred because in January 2004 it was planned that S2 would have a new Care Coordinator. It was intended that the new Care Coordinator would take over on the 1st January. In the event the transfer of the Care Coordinator was 'slowed down' because of S2's decline.[17]

This meant that S2 did not have a CPA Review in the eleven months since the last review. There was therefore no opportunity for the multi-agency team to come together to discuss S2's management.

It is the impression of the Investigation Team that the Black Drugs Project and Shelter Tenancy Support workers would have welcomed the opportunity for a 'round table' discussion regarding S2. The Shelter Tenancy Support Worker in particular believed that such opportunity would have enabled a range of strategies to have been discussed that may have supported increased opportunity for engagement.

[17] At the time this decision was made the Team Manger believed that stability of Care Coordinator for S2 was important and transfer of Care Coordinator therefore inappropriate.

2. The Care Coordinator assigned to S2 had no insight into the Somalian Culture, including the culturally established social habit of smoking Khat.

Comment:
A significant hurdle for S2's Care Coordinator was her stated lack of knowledge about the Somalian Community and its customs. Following a number of meetings with this individual it does appear that she did not undertake any activity to inform herself about the Somalian Community or its customs, most notably the chewing of Khat in the male members of the community. S2's Care Coordinator was not able to explain why she did not access information that was readily available to her via the internet or the Trust's own Transcultural Team[18]. With regard to the SMHP, a group that could have enhanced her own knowledge and understanding in spite of S2's unwillingness to engage, it is the Investigation Team's impression that S2's Care Coordinator had grown frustrated with this group following the lack of response to her telephone calls and correspondence with this group on the 14th May 2003

3. The Team Manager for the Continuing Needs Service responsible for the care and management of S2 made a decision to delay the allocation of a new Care Coordinator to S2 in December 2003.

Comment:
Following a home visit to S2 on the 2nd December when his Care Coordinator felt at risk, largely due to S2's inappropriate behaviour and amorous expression, the Team Leader for West CNS agreed, on the 8th December, that whilst S2's Care Coordinator would remain in-situ for the present she would not visit S2 again until a male colleague could visit with her. This took place on the 9th December. The intention at this time was that a new Care Coordinator would be allocated to S2 as soon as was practicable.

The clinical notes give the impression that S2's Care Coordinator was still working towards a relinquishing of her Care Coordination responsibility in mid December as it is recorded on the 19th that she would introduce him to his new Care Coordinator (the proposed date for this is not documented). However the next reference to S2's new Care Coordinator is on the 14th January 2004 when the person's name is documented in S2's records.

When the Investigation Team interviewed the Team Leader for West CNS he advised that he was very aware of the complexities of finding an appropriate Care Coordinator for Service Users where there are recognised difficulties in allocating a female worker. When S2 was appointed a female Care

[18] The lack of contact with TCT is particularly noteworthy as S2's Care Coordinator had worked with another Somali Service User and the TCT Somali Worker prior to the incident involving S2. Her expressed lack of understanding about the Somali Community was therefore somewhat concerning. The Investigation Team understands from this individual's Team Leader that since 2003 her levels of confidence have improved and that her overall performance within the team is of a good standard. The Investigation Team is confident that the personal circumstance of this worker was a significant influence on her levels of sickness and performance in 2003 and these circumstances are no longer an issue.

Coordinator, on the 16th December 2002, there were no male workers that could be allocated. When the continuation of a female Care Coordinator for S2 became untenable, in December 2003, he was therefore quite prepared to allocate a new Care Coordinator to S2.

However, during December 2003 there were a number of indicators that S2 was relapsing and the Team Leader believed that a change in S2's Care Coordinator at this time would be counter productive. He believed that stability in Care Coordinator was required. Furthermore it is not recommended practice to change a Service Users Care Coordinator during periods of crisis or unsettlement.

Although the Investigation Team appreciates the Team Leader's decision making process a factor that does not appear to have featured was the inability of the current Care Coordinator to establish a therapeutic relationship with S2. S2's Care Coordinator had experienced a number of sickness absence periods and much of her contact with S2, following her return to work, had been via telephone rather than face to face assessments.[19] Furthermore this Care Coordinator lacked confidence in working with the complexities S2 presented.

It is this lack of therapeutic relationship that the Investigation Team believes should have been the dominant factor in the West CNS Team Leader's decision making. If sufficient weight had been given to the lack of therapeutic relationship the Investigation Team suggests that the Team Leader may have effected the change of Care Coordinator earlier than he did. How much difference this would have made in the ability of the Mental Health Service to engage S2 is difficult to say, on balance it is probable that there would not have been any remarkable change. What may have been different however was the frequency of face to face contact with S2 that may have enabled a more informed assessment of his mental health state and more assertive action.[20]

[19] It is important to note that between the 2nd December and the 19th December 2003 S2's Care Coordinator made excellent effort to communicate with S2 by telephone and attempted a home visit. However, after the 19th December there was little to no contact with S2. This was largely as a result of his non-availability.

[20] Excepting the assessment of S2 by the Court Diversion and liaison Service on the 19 January 2004 there was no face-to-face contact between S2 and the Mental Health Service between the 19 December 2003 and the incident date the 2nd February 2004.

4. S2 himself demonstrated a consistent lack of interest in any of the services made available to him regardless of whether these were offered by statutory or non-statutory agencies. The overriding impression of S2 is a person who had the capability and capacity to engage with any of the services and support networks available to him had he wanted this.

Comment:
All of the services that had any contact with S2 described a person who was well educated, articulate with excellent English. He was a known member of the Somali Community. One of the workers in the SMHP, who had known him for some five years, is reported to have been surprised when he was admitted under Section Two of the Mental Health Act in November 2002 as he had seen no evidence of mental illness in him prior to this. Another worker at the SMHP told the Investigation Team that

"S2 was indeed an independent person who spoke good English and knew the ways and the culture of this country. This gave him a sense of independence and he was not engaging with our service."

S2's Tenancy Support Worker also told the Investigation Team that S2 was manipulative and able to "work the system" to his advantage. S2 was, in the Tenancy Support Workers opinion, able to 'vote with his feet' and able to perform when it mattered. S2, he believed, was determined not be readmitted to hospital and would present himself appropriately to avoid this.

The document analysis and interviews undertaken also revealed a person who had the ability to present himself as engaging with different services. For example he left an impression with the SMHP that he was heavily reliant on his Care Coordinator when he in fact had very little contact with her at all. Similarly S2 gave his Consultant Psychiatrist the impression, in June 2003, that he was engaging positively with the SMHP when he clearly was not.

Discussions with S2's Care Coordinator, and other involved professionals in contact with S2, revealed that whilst S2 did display behaviours that escalated the levels of concern about his mental health state he was also able to present himself plausibly for concentrated periods of time. On such occasions these professionals told the Investigation Team that there were no signs of mental illness detectable. Two examples of this are:

- On the 19th December 2003, a home visit to S2's flat was made by his Care Coordinator and the Team Manager for the CNS. This visit was prompted by significant concerns S2's Care Coordinator had regarding his mental state. At the time of this visit S2 told both professionals that he was no longer paranoid and that his paranoia the previous time his Care Coordinator visited (2nd December 2003) was due to alcohol. Neither professional was able to discern any evidence of psychosis or mental illness.
- On the 19th January 2004, S2 was assessed by a Forensic CPN working for the SCT Mental Health Diversion and Liaison Scheme. This individual spent approximately 45 minutes with S2 and stated that

"objectively there was no evidence of hallucinations, delusional ideas, thought blocking or other cognitative impairment. He was well orientated". The letter to S2's GP also states that "there was little to suggest that *S2* is currently seriously mentally ill".

- 23rd January 2004, S2 attended Harden House to take responsibility for the damage to the windows that he had damaged. The Housing Officer he met there reports that S2 was largely pleasant and appropriate throughout their meeting. (Note: S2 did however tell her that he loved her at the end of the meeting).

More General Issues:

In addition to the four significant factors detailed above the Investigation Team identified a broader range of issues that it believes contributed to the non-engagement of S2 with the Mental Health Services. The issues detailed below, in some instances, will have had a bearing on one or more of the factors detailed above:

Task Factors

- Whilst S2's Consultant Psychiatrist told the Investigation Team that he believed S2 had Paranoid Psychosis the Investigation Team did not get a sense from any of the staff engaged in S2's treatment, other than his Consultant Psychiatrist, that there was any clarity regarding the treatment plan, or agreement with this diagnosis. The overriding impression gained from staff was that they believed that S2 had a Drug Induced Psychosis[21]. It is this diagnosis that is recorded in S2's clinical records on the 4th December 2002.
- At the time S2 was receiving care from the mental health service in Sheffield, S2's Consultant Psychiatrist and Care Coordinator made their clinical notes in separate records. That there was not one set of records for S2 appears to have been driven by the different geographic bases for S2's Consultant and Care Coordinator. Consequently if the Care Coordinator could not be present at an out-patient's appointment the Consultant did not have access to the current progress notes made by his Care Coordinator records and thus lacked up-to-date knowledge about the client[22]. This lack of contemporary information is evidenced in the letter from S2's Consultant Psychiatrist to S2's General Practioner (GP) on 25th June 2003 following an out-patient's

[21] Drug induced psychosis is a recognised diagnosis and included in ICD10. The psychosis normally occurs shortly after use of drugs and resolves at least partially within 1 month and fully within 6 months. As it says in ICD10 'particular care should be taken to avoid mistakenly diagnosing a more serious condition (e.g. Schizophrenia'). As a differential diagnosis it is fine. However in the case of S2 the Mental Health Workers seem to have assumed it was drug induced and didn't show much evidence of an open mind. Had an open mind been kept this may have altered the assessments of the patient which seem to have been seen as separate episodes related to drugs with normality in between rather than a longer term overview of related incidents indicating possible mental illness

[22] This Consultant informed the Investigation Team that having now read the records made by S2's Care Coordinator that he was going to ensure, with the help of his secretary, that he had any relevant information from the INSIGHT System available at Out Patient's in future.

appointment on the 12th June 2003, where the letter states "it seems from looking at him today that the Olanzapine 10mgs has been very helpful to him and the excellent psychological support he is getting from his Care Coordinator has really put him back on the right path to health" and "He is actually linking up with the Somali Project and looks as though with his Care Coordinators good support he is moving forward." An analysis of the Care Coordinator records quickly demonstrates that S2 was not engaging with her at all.

- S2 was not referred to Sheffield Outreach Team (SORT). The main reason for this was because he did not meet some of the criteria for referral[23]. At the time he was a patient a number of audit exercises took place within the CNS teams citywide in October/November 2003 to identify clients for transfer to the assertive outreach teams in view of their increased capacity at this time. The West CNS discussed all potential candidates for referral in 1:1 supervision with some staff and collectively in team meetings. Approximately 30 Service Users were identified for referral to SORT but not S2. The West Team manager acknowledges that regardless of his ineligibility for SORT S2 did require an assertive outreach style of contact with the Mental Health Service.
- The 'risk history' recorded about S2 at all stages of his contact with the statutory Mental Health Service in Sheffield was rudimentary.
- There was at the time of his detention on the in-patient ward no specifically designed risk assessment form and while it is clear from the records the nature of S2's risks what is not clear are the circumstances and context in which S2's risky behaviour were and are displayed.
- S2's Care Coordinator told the Investigation Team that she recorded the risk history but did not explore with S2 the circumstance or context of his risk behaviour. An analysis of the CPA Risk Assessment and Management document (page 1) revealed that on the 16th January 2003, S2 was considered of medium risk to self and others. However there is no adequate description of the current concerns. The notes simply state that "S2 remains an informal inpatient on X Ward. He spends a lot of time sleeping elsewhere, unclear about where. Very forgetful, missed several appointments I've arranged with him. Drinking alcohol and chewing Khat, unclear to what extent" S2's Care Coordinator attributed her lack of exploration at the time to a lack of training in how to perform and record a good quality risk assesment with a client. She told the Investigation Team that she was now much more confident and more fulsome in her exploration of, and documentation of, risk with persons to whom she was allocated.

[23] Eligibility criteria for SORT included a history of high use of inpatient or intensive home based care, e.g. more than 2 admissions or more than 6 months inpatient care in the past two years as set out in the DOH guidance.

Team Factors (including inter-agency working relationships)

- At the time S2 was receiving Mental Health Services in Sheffield there was a tendency amongst mental health professionals to place an overt focus on the significance of drug and alcohol misuse in the presentation of their clients. There is little evidence that staff explored S2's behaviours with him. That he had attracted a diagnosis of 'Drug Induced Psychosis'[24] would have exacerbated the team's focus on S2's substance misuse issues. All of the professional staff we spoke with confirmed that this tendency existed and continues to exist today. **Note:** This preoccupation with a Service User's substance misuse behaviours is not unique to Sheffield.
- Following the assessment of S2 by his Care Coordinator and the Team Leader for WCNS on the 19th December 2003, a decision was taken for there to be 'joint visits'[25] in future for S2. However the nature of the work within a Continuing Needs Service makes joint visiting challenging. S2's Care Coordinator would have had to negotiate with a colleague the coordination of the joint visit taking into account her colleagues' caseload as well as her own. This did mean that a number of intended visits to S2 had to be rescheduled which was not ideal.

Family Factors

- In spite of many attempts to do so S2's Care Coordinator was not able to gain the support of S2's family in providing a package of care to him. An analysis of S2's records revealed that his brother would not accept the Care Coordinators concerns about S2 and believed that her efforts to engage S2 were making him worse.

Personal Beliefs and Perceptions

- It is clear from interviews with S2's Care Coordinator, and S2's Tenancy Support Worker that S2's Care Coordinator did believe that S2's predominant issue was his Khat, alcohol and Cannabis misuse. The records of S2's Tenancy Support worker note on the 16th January 2003, that the Care Coordinator believed that S2's mental health state was OK and that his chaotic behaviour was as a result of his Khat and alcohol use.
- There was a dislocation in the perception of the models of care that S2's Care Coordinator tried to employ in her efforts to engage with S2, and the impression other workers, most notably the Tenancy Support Worker at Shelter, had. S2's Care Coordinator saw herself as 'creative' in her efforts to engage S2 whilst the Tenancy Support Worker perceived her to be 'rigid' in her style of work. Interviews with S2's Care Coordinator revealed a strong belief that 'a person must want to help

[24] The clinical records of the Consultant led multi-disciplinary ward round of the 4th December 2002 note S2's diagnosis as "? Drug Induced Psychosis"

[25] Joint Visits: It is sometimes necessary for visits to Mental Health Service Users to be undertaken in two's. This is usually for the safety of the professionals involved. In the case of S2 he had made a number of inappropriate comments to his Care Coordinator and in the interests of continuity of care and her personal safety the Team Manager believed it appropriate for joint visits to be instigated form this point.

themselves. If they don't then this is a personal choice'. One did not get a sense that this individual was sensitive to the fact that some people are unable to embrace this degree of personal responsibility when they are acutely ill or in decline. That S2 was not believed to have a serious mental illness would have affected the degree to which he would have been expected to exercise restraint in his self damaging behaviours.

- The mixed perceptions of staff engaged with S2, coupled with the lack of unity in his diagnosis lead to a less targeted and coordinated management plan than was required for S2.

Cultural Issues

- There was, and is, a suspicion amongst the Somali Community and other BME groups, regarding medicines prescribed by Western Mental Health Services. Somali's believe that such medicines are terrible for a person as the person becomes 'Zombified'. In such communities it is almost preferable for the person with mental health needs to be making outbursts and displays of inappropriate behaviour as it shows that the person has spirit. With medication the spirit is seen to have been removed. A common term within the Somalian Community for persons on mental health medication is 'the slow walker'. With regard to medication generally the Somalian Community does not hold non-mental health medicines in suspicion.
- There are recognised issues around the Somali Community's inability to deal with mental illness especially once the traditional routes of faith healing have been exhausted. There is fear within the community of the western approach to treating persons with mental illness. The SMHP told the Investigation Team that they still see parents and other family members who ask them to help a loved one but 'please no injection'.[26]
- The Team Leader at the Black Drugs Project also told the Investigation Team that they have clients from the Somalian Community who will not have anything to do with local support structures. This reluctance to engage with local support structures provided within the community was also highlighted by a range of mental health professionals and the Transcultural Team. It seems that because of the tight knit nature of the community persons with mental health issues can be concerned about the level of confidentiality and the risk of breaches in this.
- Chewing Khat is seen as culturally normal and it is difficult to persuade those within the community who need to desist for the benefit of their mental health to do so.

Skills, Rule and Knowledge Based Performance

- The Investigation Team did not get a sense that S2's Care Coordinator had any depth of experience of working with complex and challenging Service Users. Consequently S2's Care Coordinator was not experienced in delivering the more flexible model of care that one might observe in the Sheffield Out Reach Team or in professionals who have been exposed to this model of work.

[26] Information gathered at a meeting with SMHP on the 20 February 2006.

- S2's Care Coordinator did try a range of techniques with S2 such as Psycho-Social Intervention to try and engage him, however the Investigation Team did not feel that this Care Coordinator appreciated that these types of interventions were unlikely to be effective for people such as S2. PSI, for example, requires a degree of personal responsibility and commitment to making self change. These were not characteristics that S2 displayed to those trying to work with him.
- There appeared to be little in the way of contingency planning should S2 deteriorate at any stage following his discharge from the in-patient ward in March 2003. One of the factors the Investigation Team believes influenced this was a lack of understanding of the critical importance of contingency planning as an integral component of good care planning for, and with, a Service User. S2's Care Coordinator told the Investigation Team that it was not her usual practice to write a risk management/contingency plan.
- There was a there was a lack of appreciation in the significance of S2's deteriorating behaviours and in the escalation of these behaviours.

Personal Issues

- S2's Care Coordinator experienced a number of periods of ill health following S2's discharge from the in-patient unit. Although unavoidable they did create a hiatus in the care delivery for S2.

Patient Factors

- S2 had a number of friends outside of Sheffield. There was a consistency in the recollections of S2's Care Coordinator and his Tenancy Support Worker that S2 was often not in Sheffield.

2. The period of time S2 was detained under Section 2 of the Mental Health on an in-patient ward in Sheffield did not result in an effective assessment of his mental health state and consequently there was uncertainty and ambivalence regarding his diagnosis.

On the 11th November 2002, S2 was admitted to one of the SCT's Adult Service Acute In-Patient Wards following his detention under Section 2 of the Mental Health Act. Section 2 of the Mental Health Act is designed to provide a period where mental health professionals can undertake a sustained period of assessment of a person believed to be suffering from mental ill health, to reach a diagnosis of their mental illness and to initiate treatment to enable the stabilisation of the person's mental health. In the case of S2 the situation was complex. The ward staff were faced with a patient who did not want to cooperate and who would display significant degrees of aggression in order to get his own way. Effecting an assessment and diagnosis of S2 was going to be challenging whatever measures were taken by the In-Patient Team.

The most significant influencing factors contributing to the ineffective assessment and lack of clarity regarding S2's diagnosis were:

- There was a lack of an agreed, and clearly documented management plan for S2 while he was an in-patient.
- The lack of containment of S2 during the period of his assessment.

Other factors that appear to have contributed to S2's lack of containment and the uncertainty regarding his diagnosis were:

Task Factors:

- The first evidence of a detailed risk management plan for S2 is on the 28th November, 17 days after his admission to the in-patient ward. While the document does detail S2's risk behaviour of absent without leave, breaking into derelict buildings and threatening to burn down the housing complex his brother lived in, the document does not detail the inpatient team's plan for containing S2.
- The Investigation Team were told that in-patient staff do sometimes lock the ward to prevent a Service User from leaving. This would normally occur if the person presented a significant risk to self or others. The documentation of any such action takes place on a specifically designated form. The Investigation Team asked to see copies of the forms completed for the month of S2's detention to ascertain whether this intervention was used to enhance the containment of S2. Unfortunately the ward records could not be located. The Ward Manager however was keen to advise that he and his staff do use the 'lock doors' option to achieve successful containment of a Service User where necessary.

- The Investigation Team perceived that the decision to lock a ward is seen as a nursing activity and not one that the MDR participates in. The practicalities of activating the locked door policy means that at the time the decision is made it will usually be a nursing decision. However the appropriateness of utilising the locked door policy should feature in the MDT discussion regarding the management and containment of a client and be documented as an agreed containment strategy. There is no evidence that this occurred when S2 was an in-patient, or that it would occur now.
- The Investigation Team did not get a sense from any of the staff they spoke with that there was any considered plan for containing S2 other than instituting timed nursing observations. In the case of S2 these ranged from 15 minute intervals to constant observation following S2's attempt to smash his way-out from the ward with a fire extinguisher. Although it is not appropriate to sustain constant observation on a Service User 15 minute observations are not an effective way of preventing AWOL episodes. The location of the In-patient Ward meant that in 15 minutes a Service User who went AWOL could be en-route to, or in the centre of Sheffield.
- If a patient is trying to leave the ward without permission and there is an assessed risk of harm to self if one were to try and prevent this, then the advice of the Trust's Management of Violence and Aggression Training is to let the person leave and to call the police. This advice is perfectly reasonable. However S2's Named Nurse did tell the Investigation Team that he was confident that if S2 did leave the ward then either he or his colleagues would have made good effort to follow him and to effect his return to the ward if they could.
- A referral was made to the Intensive Treatment Service by the Deputy Ward Manager on the 27th November 2002. A member of the ITS team attended the multi-disciplinary ward round as part of the assessment process of S2's suitability for the ITS. At this time ITS noted that no treatment plan had been commenced for S2 and their advice to the Inpatient Ward was to commence this as the first step in trying to evolve the effective management of S2. The ITS record reads;

  "Outcome: Undecided, Inpatient Ward to initiate treatment plan this afternoon. May require transfer to ITS department dependant upon his response and if further absconsion continues"[27]

  S2's aggressive behaviour did settle but his absconding behaviour did not. S2 effectively treated the In-patient Ward like a hotel. The Investigation Team did not receive a reasonable explanation as to why S2 was not subsequently re-referred to ITS. It seems as though the focus on the long term engagement and relationship with S2 predominated and the purpose of his admission did not predominate.

[27] Criteria for ITS – Non-engagement, Non-compliance with treatment, violent behaviour, persistent behaviour.

Leadership and Clinical Decision Making:

- On the 29th November, S2 was granted Section 17 Escorted Leave with either a staff member or a family member by his Consultant Psychiatrist. This decision was made because the staff on the ward were concerned that S2 'would make violent attempts to leave' if no compromise position was reached. The documented rationale for implementing Section 17 leave was to 'test *S2's* mental state and behaviour'. While the Investigation Team appreciates that this was a team decision it runs counter to the purpose of S2's detention, i.e. assessment and treatment. It was already known to the team that when not on the ward S2 was using Khat, alcohol and Cannabis. The decision to proactively support leave periods, albeit escorted, the Investigation Team asserts was an error of judgement in the management of S2.
- Following the decision to allow S2 Section 17 Leave, there was no revision of this once it became clear that S2 was not going to respect any of the boundaries agreed. S2 constantly took unauthorized leave, and frequently failed to return to the ward within the agreed time period when authorised leave was taken. S2 essentially used the In-Patient Ward as a base, coming and going as he pleased. His Consultant Psychiatrist did not take any decisive action to ensure that the purpose of S2's admission was achieved, i.e. effective assessment.
- The model and philosophy of S2's Consultant Psychiatrist focused on building a trusting relationship with his patients. Whilst it seems that he was appreciative of the need to effect containment for patients requiring assessment he did not necessarily believe that enforcing this was in the longer term best interests of the client or their relationship with Mental Health Services. This Consultant did not therefore often consider use of the Intensive Treatment Service. This in itself is not unreasonable but the Investigation Team does not believe that S2's Consultant Psychiatrist or Ward Team gave sufficient regard or attention to the purpose of S2's admission to hospital or the risk to S2 if an effective assessment were not achieved.

Team Factors

- S2's Consultant Psychiatrist did not perceive S2 to be dangerous rather a 'nuisance'. However he also told the Investigation Team that the medical staff may not have been as aware of his (S2's) behaviours as the nursing staff.
- It is clear from the clinical records that on the 29th November 2002, the ward team decided to provide escorted leave for S2 because they believed he would make violent attempts to leave the ward if a compromise position was not reached. (S2 had on the 26th November smashed his way into the secure garden with a fire extinguisher after being advised by the House Officer that it was inappropriate for him to leave the ward as they needed to assess him free of alcohol and drugs). At this time S2 was promising to 'behave' himself and to return to the ward promptly, i.e. within the parameters agreed.

- Both S2's Consultant and named nurse believe that the building of trust with a patient is paramount to enabling effective engagement with the Mental Health Service. Both practioners demonstrated an awareness that there is a balancing act between enforcing the rules and finding a middle ground (note: while the clinical records say that the team was aware of the risks, the Investigation Team feel it would not be feasible to achieve an effective assessment of S2 whilst he remained in a position to abuse Khat, alcohol and Cannabis). S2's Consultant psychiatrist informed the Investigation Team that people with psychosis often have a distrust of the service and blocking the symptoms with powerful drugs is only part of the picture, building personal relationships and giving new role models he believes is very valuable.
- Discussion with S2's Named Nurse and the Ward, leave one with a sense that staff were lulled into a false sense of security by the fact that S2 always returned to the ward, even if this was in his own time scale. This appears to have been interpreted as a degree of engagement with the service. However without the shelter the ward provided S2 would have been homeless.
- The Investigation Team sensed that if staff believed that a patient had a drug-induced illness then this could lead to a mixed approach in respect of the patient's treatment. That the treatment could be less assertive if the predominant feature in a persons presentation was believed to be substance misuse, was reaffirmed for the Investigation Team in almost every interview held with SCT staff. **Note:** This is not unique to Sheffield; however this perspective regarding S2 did affect how he was managed both as an in-patient and subsequently in the community.

Patient Factors

- S2 presented a very changeable picture to the staff on the Inpatient Ward. He was, his Consultant Psychiatrist asserts, assessed by some very competent persons, but that he (S2) was confusing and puzzling to most.
- The records reveal that on many occasions staff did not find any evidence of a mental illness in S2.
- Three-to-four drug screens were attempted when S2 returned to the ward but S2 would not consent to these. On the 14th November (3 days after admission) the clinical records also detail an occasion where S2 was asked to provide a urine sample when the staff were concerned that he had been using Cannabis. It is clearly recorded that S2 was unable to provide a sample at this time.
- S2 displayed a range of behaviour while he was on the In-patient Ward. Although he could be unpredictable and capable of displays of violence if he did not get his own way he was also able to present himself appropriately and demonstrate an ability to abide by the rules stipulated. These demonstrations of compliance were sufficient to convince staff that progressing a more flexible approach regarding his care and management was appropriate. Of particular note is that S2

did appear to settle down once he had been discharged from his detention under the Mental Health Act.

- S2 quite simply did not want to be contained on the ward and would come back drunk or having used Khat or Cannabis.

Working Environment Factors:

- S2 was managed in an open ward where absconsion was relatively easy to effect and where the regime and culture at that time appeared to contribute to this situation.
- The layout of the in-patient ward provided a range of opportunities for a patient to leave if they wished. The ward had a main and rear entrance with the main entrance leading directly onto an outside path, and the rear entrance onto a corridor with direct access to the car park. The garden that was reputedly secure had a metal rail around the roof that was angled in such a way to make using it as an aide to escape possible for anyone who was determined to make their escape across the roof space. All one would need is a chair or table dragged to the wall as the ward was a single story building.

3. Between December 2003 and February 2004 there were two occasions where S2 should have had his Mental Health State assessed with a view to offering him an informal admission or detention under the Mental Health Act. One of these was in early December 2003 and the other at the end of January 2004.

The circumstances surrounding the chain of events in December 2003 and January 2004 were markedly different. As a consequence the context and contributory factors to the non-assessment of S2 on both occasions have been set out separately below:

December 2003
Contextual Overview:
Following his discharge from hospital on 7th March 2003, S2, whilst not particularly engaging with the support offered to him by his Care Coordinator did not cause any undue concern regarding his risk to self or others. On the 2nd December (Tuesday) there was a marked change in his presentation and his Care Coordinator 'felt intimidated and at risk[28] during the period she was at S2's home. At this home visit, S2 told his Care Coordinator that he loved her and that he was going to target a Somali Police Officer in London. S2 is noted to have 'presented as extremely paranoid and suspicious, and felt like he was being watched and followed.'

Following this home visit S2's Care Coordinator made contact with the Custody Sergeant at Bridge Street Police Station. S2's Care Coordinator advised the Custody Sergeant that she believed that S2 was relapsing and a risk. Information relating to S2's reported intentions regarding the Somalian Police Officer were communicated.

On this same day S2's Care Coordinator

- made contact with S2's Consultant Psychiatrist, and faxed information to him. S2's Consultant Psychiatrist agreed to make time on the 5th December (Friday) for a Mental Health Act Assessment,
- spoke with the Duty Approved Social Worker (ASW) about her concerns,
- notified the Tenancy Support Worker for S2,
- tried to make further contact with S2 and spoke with his brother. His brother agreed that S2 'seemed a bit different but not much'.

The following day S2's Care Coordinator spoke with another ASW working with the West CNS. He advised that she clarify with S2's Consultant Psychiatrist his plan for Friday Morning.

On 4th December (Thursday) S2's Care Coordinator received a telephone call from S2's Consultant Psychiatrist where an agreement

[28] Taken from the clinical records and file report prepared by S2's Care Coordinator.

was made to meet at the West CNS base the following morning to discuss the situation. S2's Care Coordinator notified S2's GP surgery that one of them may be required for a Mental Health Act Assessment the following day. She also discussed the situation with her Team Manager in Supervision.

On 5th December the meeting to agree a way forward regarding S2 took place. The outcome of this meeting was that S2's Consultant Psychiatrist

- told S2's Care Coordinator that he was reluctant to use the Mental Health Act unless it was absolutely essential,
- that he would rely on the 'good judgement' of S2's Care Coordinator.

The clinical records clearly show that this Care Coordinator was not happy with the response of S2's Consultant. The concerns of the Care Coordinator are precisely documented.

Comment

It would seem that on the 5th December that there was a lack of clarity as to whether S2's Care Coordinator actually asked for, and arranged, a Mental Health Act Assessment. All of the records and interviews suggest that this was not the case. **Note:** At this time S2's Care Coordinator had completed her ASW training but was not functioning in this capacity.

It may seem like splitting hairs but there is a significant difference in;

- a Consultant Psychiatrist declining to make his/her own assessment of a patient,
- a Consultant Psychiatrist refusing to attend for a Mental Health Act Assessment.

It is the impression of the Investigation Team that S2's Consultant Psychiatrist declined to make his own assessment of S2 but did not refuse to attend for a Mental Health Act Assessment.
Nevertheless it is unsatisfactory for a senior colleague to refuse to support less experienced colleagues when they are concerned about a Service User and their risk of relapse. The information documented by the Care Coordinator should have been sufficient to prompt this.

In addition to S2's Consultant Psychiatrist's lack of support to a colleague the Investigation Team is concerned that there was no escalation of the concern if the Team Leader believed that S2's Care Coordinator was asking for a Mental Health Act Assessment.

Meetings with a range of staff, including S2's Care Coordinator and Consultant Psychiatrist at the time revealed:

1. That S2's Consultant Psychiatrist did have a tendency to leave decision making and case responsibility to the individual worker rather than providing clinical leadership when required.
2. That S2's Care Coordinator did not have a particularly assertive communication style at the time and may not have expressed as clearly as she believed, what she wanted for her client, i.e. an assessment under the Mental Health Act.
3. That the Team Manager for West CNS and the Clinical Lead for Services for Adults of Working Age were both aware of communication issues between S2's Care Coordinator and S2's Consultant Psychiatrist. The Clinical Lead told the Investigation Team that she was not aware specifically that S2's Consultant Psychiatrist had refused to undertake an assessment of S2. Had she been aware she advised that she would have spoken directly with the Consultant if the refusal had been to undertake a Mental Health Act Assessment. If the refusal was simply not to assess a patient the then Clinical Lead was not confident that she would have intervened. She was relatively unseasoned in her role at the time and suggests that she would not have had the level of confidence to challenge a more Senior Consultant about his personal decisions.
4. That S2's Consultant Psychiatrist believes himself to be supportive and he told the Investigation Team that had S2's Care Coordinator made clear her concerns then without a doubt he would have gone to see the patient. When this individual was shown the Care Coordinators record of their meeting on the 5th December the Consultant Psychiatrist was visibly shocked. (The 1st March 2006 was the first time that this record had been shown to him). The Consultant told the Investigation Team that he had not made any records of the meeting in the medical notes so a comparison of recollection was not possible. In light of what the Care Coordinator had written the Consultant told the Investigation Team that he was at a loss to explain why he did not act appropriately to support his colleague.
5. Whilst the Team Leader for West CNS went to discuss the situation with S2's Consultant Psychiatrist it was not his practice to direct the actions of medical colleagues. He told the Investigation team that he would use persuasive argument appealing to an individual's professionalism, duty of care to another colleague, and duty of care to a Service User. Furthermore this Team Manager did not believe he had a mandate for telling a member of the medical staff what to do.
6. At the time this clinical disagreement took place there was no defined pathway for escalating a concern where local resolution had been ineffective. Nevertheless the Investigation Team are

bemused as to why concerns were not communicated up the management and clinical hierarchy. The following specifically may have influenced this;

- S2's Care Coordinator was perceived to over exaggerate risk behaviours in her clients. This was one reason why the West CNS Team Leader believed it necessary to assess for himself the situation with S2,
- the culture in SCT at the time was not conducive to management staff interfering in clinical decision making.

7. Compulsory admission for Service Users is a complicated area and one that seems to have caused confusion in the West CNS. Furthermore during interviews with contemporary staff the Investigation Team sensed a lack of clarity regarding the roles and responsibilities of individual team members in utilising the Mental Health Act to achieve a compulsory admission. This situation is not unusual within the Mental Health Service.

   The 1983 MHA places responsibility for compulsory admission to hospital on the application by an ASW, or nearest relative, and two doctors. One of these must be a specially trained Section 12 Doctor/Psychiatrist and the other is usually the person's GP.

   The practicalities of progressing an assessment with a view to compulsory admission can vary between localities and NHS Trusts.

   In the case of S2 it appears that there was an expectation that it was the role of the Consultant Psychiatrist to initiate an MHA assessment. In reality the Care Coordinator could have asked for an assessment under the MHA. There is no evidence that S2's Consultant Psychiatrist was asked to attend an MHA.

   Had this occurred and S2's Consultant Psychiatrist had not been available then another Section 12 Doctor could have been asked to attend the assessment. If a request to attend for an MHA assessment is made and the Consultant Psychiatrist refuses to attend, without very good reason, one would expect this to be escalated at least to the Clinical Director for the service, preferably to the Medical Director for the Trust.

The Investigation Team believes points one, two, five, and six to be the most influential contributory factors.

January 2004
Contextual Overview:
From 5th December 2003 – 13th January 2004 the situation with respect to S2 was relatively calm. He was assessed by the Team Leader for West CNS on the 19th December with S2's Care Coordinator. At this visit S2 told his Care Coordinator and the Team Leader that his previous behaviour was as a result of drinking alcohol. To the Team Leaders recollection S2 was appropriate in his behaviour while they were in his home and he displayed no evidence of psychosis or mental illness.

The next significant record is on the 13th January 2004. On this day S2's Care Coordinator received a telephone call from S2's Tenancy Support Worker advising that S2 appears not to be at home but his windows are open and his TV is on. The situation remained the same when the Tenancy Support Worker visited later that day. Concerned S2's Care Coordinator tried to make contact with S2's brother and other family members. These attempted contacts were unsuccessful.

On the 14th January S2's Care Coordinator received a call from a Housing Officer advising that one of their team was at S2's flat. All risks and the current situation was communicated to them. S2's Care Coordinator notified the Tenancy Support Worker who confirmed that the police had been called. S2's flat was secured but there was no sign of him.

On the 19th January S2 was assessed by the Mental Health Court Diversion and Liaison Team. This assesment revealed that there was 'little to suggest that S2 is currently seriously mentally ill. He was pleasant and co-operative throughout our contact and told us about his past contact with psychiatric services. He was able to tell us that he had been thought to be psychotic in the past and gave us a good description of what being psychotic meant. He denied that he was currently having similar experiences. He said that he had had feelings that his TV was talking to him about a month ago but denied such feelings at the moment.'[29]

From the 22nd January – 26th January there are continuing reports of disturbances coming from S2's living accommodation. These culminated with S2 punching a Somali gentleman in the face on the 26th January. S2 was restrained by the Housing Officer and Repair Man who was present at the time. Before the police arrived S2 punched the Somali gentleman again in the face and was again restrained. S2 was taken into custody and assessed by the Police Surgeon (Forensic Examiner) and the Investigation Team believe was subsequently released on bail.

[29] extract from the letter from the Mental Health Diversion and Liaison Service to S2's GP (19 January 2004)

The Housing Officer who witnessed the attack told the Investigation Team that she made a number of attempts to communicate the events to S2's Care Coordinator but her attempts to do this were not successful until the 30th January 2004. Once alerted S2's Care Coordinator contacted S2's GP surgery regarding his medication and learnt that S2 had not collected a prescription for his Olanzapine since the 5th November 2003. S2's case was then discussed with the West CNS Team Manager. It was agreed that S2's Care Coordinator and the Duty Social Worker would make an immediate home visit to assess S2 and to deliver Olanzapine to him.

S2 was not at home when the Duty Social Worker and S2's Care Coordinator visited. A note was left for S2 asking him to take his Olanzapine and suggesting that he contact the GP Cooperative for help. S2's Care Coordinator, the records note, was concerned that S2 was relapsing at this time.

S2's Care Coordinator also made contact with S2's Consultant Psychiatrist to update him on the situation. He agreed to 'chase up S2's notes next week and that the Mental Health Act might be a consideration'. The Out of Hours Service was also contacted to ask if they would attempt to visit S2 over the weekend. However as S2 had not given consent to their intervention and a Mental Health Act Assessment was not being requested they were not able to undertake this[30].

2 February

S2's Care Coordinator made a telephone call to the Housing Officer who advised that complaints had continued over the weekend regarding the noise coming from S2's flat. This worker herself had seen S2 that morning walking up the road away from his flat leaving 'his noise on'.

The Care Coordinator also made a call to

- S2's brother asking him to call her as soon as possible,
- the charge office to advise that S2 needed a doctors assessment if he was arrested again.

There was also a West CNS team meeting on this day involving S2's Care Coordinator, the Team Manager, a Clinical Psychologist and S2's future Care Coordinator. After 'a lengthy discussion' it was agreed that things were not quite at the point where a Mental Health Act Assessment could be progressed because S2 was exhibiting periods of rational lucidity. Interviews undertaken by the Investigation Team and

[30] In 2002 the Out of Hours Service was a nurse and social worker led service. It's Operational Policy at the time stipulated that a Service User had to consent to their engagement, and preferably a meeting would have taken place with the Care Coordinator and the Out of Hours Service. If consent was not forthcoming this precluded the involvement of the Out of Hours Service except where a Mental Health Act Assessment was being requested. The contemporary situation is that the Out of Hours has evolved into the Crisis Intervention Service that is Consultant Led and offers a 24 hour service seven days a week.

the clinical records, demonstrate that the West CNS were aware of the 'high risk levels' but in the first instance it was agreed that the current and new Care Coordinators should visit S2 to assess him. This assessment visit was agreed between the two Care Coordinators for the 4th February at 11.45am.

16.30hrs 2 February:
The police notify S2's Care Coordinator that S2 has been arrested on suspicion of arson.

COMMENT:
While the Investigation Team appreciates that S2 presented a difficult picture to all professionals involved we do believe that there was sufficient information available to warrant assessment under the Mental Health Act following his assault on the Somalian gentleman on the 26th January 2004.

The reasons why this did not occur are understood to be:

- An over association by West CNS with alcohol and substance misuse being the underlying causes of S2's deterioration and an over reliance on the occasions where S2 was assessed as showing no evidence of serious mental illness, most notably the 19th January 2004. It appears to the Investigation Team that each episode was seen in isolation rather than as series of inter-related incidents.
- An insufficient correlation between S2's behaviours from the 2nd December – 30th January and his original presentation when he was detained under Section 2 of the Mental Health Act on 11th November 2002.
- A misguided belief that if a person has substance misuse issues then the Mental Health Act cannot be used. There was a lack of understanding in the West CNS that the Mental Health Act can be used even if there are known substance misuse issues providing the dominant reason for the assessment is to determine the individual's mental state.
- The delay in S2's Care Coordinator being aware of S2's attack on another member of his community. **Note:** This attack took place on the 26th January. The Housing Officer told the Investigation Team that she left several messages for S2's Care Coordinator to contact her between the 27th and the 30th January.[31] The first successful contact between them was on the 30th January 2004. Had the Housing Worker been able to communicate her concerns on the 27th it is possible that S2's Care Coordinator could have effected an assessment of S2 prior to the incident on the 2nd February 2004. There are no guarantees however that this would have resulted in a hospital admission on an informal basis, or via detention under the Mental Health Act.

[31] The Investigation Team has not been able to validate this information.

It is the opinion of the Investigation Team, based on the discussions and decision of the West CNS, that had the team been aware on the 27th, and no opportunity to assess S2's mental state had presented itself between then and the 30th then the status quo would have been maintained and there would have been no assertive attempt to effect a MHA assessment.

- Also relating to the 26th January is the non-communication from the Custody Officer to the Mental Health Service following S2's release on bail. Essentially the duty of the Custody Sergeant was discharged when on the advice of the Police Surgeon S2 could be released on bail. There is no established communication pathway for effective communications between the Police and Mental Health Services in such circumstances. This is a national and not a local issue.
- West CNS service did not consider an attack on a 'random' passer by' to signify sufficient risk to warrant a Mental Health Act assessment. When the Investigation Team discussed this scenario with other staff at SCT that fact that the attack was random was considered to be of greater risk because it signified an increase in S2's levels of unpredictability.
- During January 2004 the West CNS were not aware that S2 had made previous threats towards the Somalian gentleman this information only came to light during the Police Investigation following the incident of arson. Whilst these threats were known within the Somali Community the SMHP suggested that they were probably thought to be empty threats and drunken talk. Within the Somali Community it is understood that there is an unwritten rule that one does not bring aggression to the home of another community member. If a man has an issue with another man then this is addressed away from the home. For S2 to have attacked the home of another was unprecedented.
- The Housing Officer who went to visit the victim's family after S2 had punched the father in the street was informed about the threats S2 had been making. The way in which the information was conveyed led her to believe that the family viewed these threats as irritants rather than as real threats. When asked why she did not communicate the information provided to her by the victims family to S2's Care Coordinator she told the Investigation Team that she believed that she had already communicated many concerns about S2's behaviours to his Care Coordinator including his unprovoked attack and that this information added nothing to what she had already communicated. The Housing Officer also suggested that its significance may have eluded her as she hears many such stories during the course of her work.

Note: The Team Leader of West CNS asserts that if he or any of his team had been aware that S2 had been making threats towards the family of the gentleman he attacked, or the gentleman himself, this would have completely altered their perspective and they would have set out to undertake a Mental Health Act Assessment on the 30th January 2004.

The Investigation Team is of the opinion that there was sufficient information available to the team to have activated a MHA assessment in any event. It is also noteworthy that had the Out of Hours Service been asked to undertake a Mental Health Act Assessment over the weekend of the 31 January then they would have done this, providing that they were able to locate S2.

4.0 MAIN CONCLUSIONS S2

Although S2 presented many challenges to the Sheffield Mental Health Service in terms of his care and management it is the opinion of the Investigation Team that his care fell below the expected standard in a number of areas.
Specifically:

- The Investigation Team believes that the lack of effective assessment and the absence of a targeted management plan (whilst S2 was detained as an in-patient between November and December 2002 and subsequently) significantly affected the perspectives and the attitude of the Community Mental Health Service about S2's problems,
- There was no assessment of S2's mental state by his Consultant Psychiatrist in December 2002 despite S2's Care Coordinator voicing concern that S2 may be relapsing. Furthermore S2's Care Coordinator showed a lack of assertiveness in not requesting a Mental Health Act Assessment at this time,
- The lack of multi-disciplinary and multi-agency review within the Care Programme Approach (CPA), and the lack of CPA Reviews,
- An unexplained delay of five days before S2's Care Coordinator became aware of the unprovoked and apparently random attack by S2 on the Somalian gentleman (husband and father to the subsequent victims) on the 26th January 2004[32].

In addition to the above whilst the Investigation Team appreciates that there are many factors that influence a decision to undertake a Mental Health Act Assessment and that the potential need for this was clearly in the minds of S2's Care Coordinator, the Team Leader for the West CNS and S2's Consultant Psychiatrist the Investigation Team believes that there was sufficient information available to the Mental Health Service on the 30th January 2004 to warrant an Mental Health Act Assessment to be actively pursued on the 30th or over that weekend (31st January/ 1st February). The Investigation Team considers that the decision to wait until Monday morning (2nd February) to further discuss this issue was an error of judgment on behalf of all Mental Health Professionals involved in this decision making process.

The Investigation Team accepts that S2 was not an easy Service User to engage and manage. Nevertheless S2 displayed significant signs of relapse from early December 2002 through to the incident on the 2nd February 2004. It is the opinion of the Investigation Team that insufficient

[32] The Housing Officer recalls leaving a number of telephone messages for S2's Care Coordinator to make contact with her during this five day period.

attention was given to the pattern of S2's behaviours with no correlation of his relapse indicators and his presentation in November 2002. However up until the 19th January 2004 the Investigation Team feels that an assessment of S2 would not have resulted in compulsory detention.

However between the 22nd and 30th January 2004 the information provided to the Mental Health Service about S2's anti-social behaviour (by the housing officer and the Tenancy Support Worker at Shelter) was sufficient to have triggered a level of concern regarding S2's personal safety and the safety of others that should have resulted in a Mental Health Act Assessment.

Whilst one cannot predict the outcome of such an assessment the Investigation Team believe it probable that such an assessment would have resulted in the compulsory admission of S2 prior to the date of the incident.

Note: The Investigation Team is mindful that information available about S2's behaviours in the community and in particular towards the victims, was not provided to the Mental Health Service. Nevertheless the Investigation Team believes that the Mental Health Service had sufficient information to enable decisive action to be taken.

The Contemporary Situation:

Adult services are now managed in a radically different way to 2002. There is clearly defined management responsibility for quality and safety, placed equally on the Service Manager and Clinical Director for each service. This should mean that any significant difference in clinical opinion can be appropriately escalated and managed. The Trust has also developed a protocol for Dual Diagnosis and is in the process of rolling out a training programme to support this policy document. The Investigation Team hopes that this training will reduce the risk of staff overly focusing on a Service Users substance misuse issue(s) at the expense of their mental health illness.

Regarding non-containment and the appropriate and assertive use of the Mental Health Act, the Investigation Team is not confident that the lack of containment that was a feature of S2's compulsory admission would not occur today. However, this is a complex area and uncertainties in application of the Act will arise from time to time. On the basis of the questionnaire responses received the Investigation Team is satisfied that staff are familiar with their responsibilities in relation to the Mental Health Act.

The Executive Management Team for SCT and the Directorate of Acute Community, and Primary Care Mental Health Services need to reflect carefully on the recommendations made in this report. The Trust must ensure that it has, at the heart of its Service Governance, processes that enable it to assess and assure the overall standard and quality of service provided to the community of Sheffield.

Annex
Outline Chronology of S2's contacts with the Mental Health Services in Sheffield

CHRONOLOGY OF S2'S CONTACTS WITH THE MENTAL HEALTH SERVICES PROVIDED BY SCT

Inpatient Care: November 2002 – March 2003

Date	Event
11 Nov	S2 was admitted to an inpatient ward at SCT under Section 2 of the Mental Health Act.
11-13 Nov	The clinical records note that S2 is appropriate in his behaviour and settled on the ward.
14 Nov	S2 left the ward on two occasions during the day. The later episode being between 15.30 and 16.00hrs. He did not return to the ward until the 16 November. On his return he bought alcohol and Khat onto the ward. The Missing Persons Protocol was appropriately actioned.
17 Nov	S2 leaves the ward to get 'some air' with the permission of one of the ward staff. S2 does not return. Prior to him leaving the ward S2 had been repeatedly asking for leave. At this time S2 did not have S17 leave status. By the 18 Nov S2 is noted to be back on the ward.
19 – 25 Nov	This period is punctuated by persistent periods of absent with leave behaviour. On one occasion S2 is arrested for criminal damage to property and is returned to the ward by the police.
26 Nov	S2 makes a threat to burn down the housing complex he is to be evicted from following the receipt of correspondence from North British Housing informing him of this. The decision to evict S2 followed a two year history of criminal damage to the property. At 19.00hrs S2 goes absent from the ward. He is reported missing as a category A patient (ie high risk). The Housing Association towards whom the threat had been made had been informed of this earlier in the day. Attempts were made to inform them of S2's absence from the ward but this was unsuccessful. At 21.40hrs S2 returns to the ward and is placed on time observations of 15 minutes.

Inpatient Care: November 2002 – March 2003

Date	Event
27 Nov	S2 asks if he can go out of the ward and is refused permission. He threatened to 'smash his way out' if he was not allowed and subsequently used a fire extinguisher to smash through the garden door. He was restrained and taken to a seclusion room where he remained for approximately one hour. He was placed on intensive nursing support. There were no further episodes of attempted unauthorized leave. On this same day there is a multidisciplinary ward round (MDT). S2's explanation for his behaviour is becoming more fanciful. He provided explanations such as; 'it wasn't him it was his shadow', he also told staff that he was an alien from outer space. S2 showed no remorse for the behaviour he is 'accused of' and denies responsibility for it.
29 Nov	S2 again requests leave, promising to return and to behave appropriately. The care plan is for 2-3hours escorted leave at the 'nurse's discretion'. The clinical records make clear that at this time it is the ward teams opinion that S2 will make further violent attempts to leave the ward if no leave is granted. The rationale at this time is also noted as being 'to test his mental state'. Section 17 Leave is agreed. On this same day S2 also had a visitor who was seen trying to pass drugs to him and S2, himself, was being subtly offensive to another patient to the extent that it was starting to resemble bullying. It is notable that on the afternoon of the 29th when staff were unable to grant leave, because they could not provide an escort, S2 became angry and left the ward anyway. The notes reveal that he was 'pursued but quickly disappeared'. S2 returned to the ward on the 30th.
5 Dec	S2 returns to the ward having taken unauthorised leave on the 1st December. S2 claimed to have spent a few days with his sister. He does agree to depot injections on a fortnightly basis (Clopixol). S2's family is contacted via his nephew, and a request is made that the family attend the ward round the following day. Unfortunately it is the end of Ramadan (EID) which will make attendance difficult. The nephew says he will try and attend at 4pmish. The nephew advises that S2 is likely to abuse alcohol, Khat and Cannabis as soon as he leaves the ward, and that this makes him increasingly likely to 'kick off'. Following this episode the ward staff implement 'reasonably close observations' and a nurse was deployed outside the office so that 'all directions could be seen'.

Inpatient Care: November 2002 – March 2003

Date	Event
5 Dec (pm)	S2 takes unauthorised leave in the afternoon/evening and returns to the ward at 22.30hrs with a bottle of cider and Khat. He is reminded that he cannot have these items on the ward. S2 'politely and pleasantly' tells the staff that he would rather go back on leave and use them. S2 leaves the ward and returns on the 6 December at 07.30hrs.
6 Dec	S2 is regraded from Section 2 of the Mental Health Act to an informal patient. He also received his depot of Medecate 12.5mg this day.
6 Dec – 18 Dec	Much the same pattern of behaviour continues.
18 Dec	S2 is allocated a social worker as his Care Coordinator. At this time there is also the possibility that S2 will be discharged as homeless owing to difficulties in finding him a tenancy.
18 – 25 Dec	Nothing new of note
26 Dec	The nursing records show that S2 continues with some of his delusional beliefs. However the overall impression emanating from the nursing record is that S2 is not considered to be a risk to others at present. He appears to be coping well with his beliefs (that he works for the guardian newspaper, and issues with electric lights continue).
27 Dec – 7 Jan '03	Nothing new of note
8 Jan	The MDT meeting. It is noted that S2 has not been on the ward very much, only to sleep. It is also noted that he has been refused incapacity benefit and that he must pay rent arrears of £1,400. S2's usage of the ward as a place to sleep is a pattern that continues until his discharge in March.
16 Jan	There is a CPA meeting but this is not well attended. There was no family representative. It is agreed at this meeting that S2's Care Coordinator would try and negotiate accommodation for him via the Homeless Mental health Team.
24 Jan	It is made clear to S2 that unless he pays off his rent arrears he will not be entitled to any accommodation.
27 Jan	S2's Consultant Psychiatrist agrees for S2 to remain on the ward for a further month so that appropriate accommodation arrangements can be made. Over this period S2's appointed Care Coordinator meets with S2 to agree a risk management plan and to work with S2 on his relapse indicators.

Inpatient Care: November 2002 – March 2003

Date	Event
4 Feb – 19 February	Over this period S2 is noted to no longer be suffering from mental health problems. On the 19 February S2 is allocated a tenancy support worker from Shelter to assist him in obtaining a grant to furnish his flat. S2 is taking regular un-negotiated leave but this is not reported to the police as he is considered to be low risk at the time. The records note that he is engaging well with his relapse signature work. S2 receives formal confirmation of the offer of a flat on the 19 February.
19 Feb – 27 Feb	Nothing new of note.
5 March	It is decided at the MDT Ward Round that S2 will be discharged the following week. This occurs on the 7 March.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
12 March – 23 May	There is a detailed file note covering this period. This shows that S2's Care Coordinator made 20 attempted visits to S2 of which eight were successful. It is noted that S2 is responding poorly to opportunities for support including those offered by his Tenancy Support Worker. The records note that S2 did respond positively to the suggested referral to Howard Road Community Support Service but in view of his non-engagement with other aspects of his care package this referral was 'put on hold'. (Evidence of engagement is a key criteria of acceptance by Howard Road). The records show that S2 continues with his use of alcohol and Khat. **24 April:** Correspondence from S2's Care Coordinator to S2's GP notes that neither S2 or his family are entirely satisfied with his accommodation. The family's dissatisfaction with S2's management plan is also noted along with the Care Coordinators commitment to continue to try and work with them.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
12 March – 23 May cont…	**16 May:** S2's Care Coordinator writes to S2's Consultant Psychiatrist highlighting her concern that he is not taking his Olanzapine. In this letter the Care Coordinator states that she last say S2 on the 2nd May. The letter also reveals that S2 is difficult to assess as he doesn't give much away voluntarily and tends to agree with everything that is suggested to him. This letter also highlights the Care Coordinators concern regarding the risk of relapse for S2, and risk to others, if he does not take his medications. **19 May:** S2's Care Coordinator writes to S2 highlighting the difficulties she and others are having in engaging with him. The letter strongly advises S2 to stop using Khat. The letter also advises S2 that his Care Coordinator will be reducing the intensity of her visits to once per month with the support of a Community Psychiatric Nurse (CPN). **23 May:** S2's Care Coordinator visits the brother of S2 at his place of work. The records make clear that S2's brother is not happy about the treatment of his brother. The impression is that he does not agree with his detention under Section 2 of the Mental Health Act or of his continuing contact with the mental health services. S2's Care Coordinator it seems tried to reiterate the mental health service's view of S2's needs. S2's brother confirms that he has encouraged S2 not to take his medication. S2's brother terminates the meeting with the Care Coordinator.
29 May – 11 June	Nothing of note
12 June	S2 attends for an out patient appointment with his Consultant Psychiatrist. The subsequent correspondence with S2's GP notes that S2 is receiving 'excellent psychological support' from his Care Coordinator and that this has put him back on the 'right path to health'. (This is contrary to the impression gleaned form the Care Coordinator records).

Community Care: 7 March 2003 – 2 February 2004

10 July	S2's Care Coordinator has had a period of absence from work and attempts to make contact with S2 on her return. This contact is by telephone and the number she has for S2 is no longer functional. S2's Care Coordinator also makes telephone contact with the Tenancy Support worker for S2 and learns that he (S2) is making approximately 'every other appointment' with this individual. The Tenancy Support worker is noted to feel that S2's memory is poor and that most of his money is going on Khat and food. The records note that this worker also feels that S2 continues to lack motivation to take responsibility for his flat and that his memory is poor though there are no obvious signs of psychosis. The Tenancy Support Worker is due to meet with S2 the following Monday. S2's Care Coordinator asks the Tenancy Support Worker to speak with S2 about his disconnected phone. (note: S2's Care Coordinator is on a graduated return to work programme and is office based at this time. She advises the Tenancy Support Worker of her situation).
22 July	S2's Care Coordinator verifies with his GP surgery that S2 is collecting his repeat prescriptions of Olanzapine.
28 July	S2's Care Coordinator writes to him to advise that she has returned to work on a part-time 'office based' basis. The correspondence advises that she will contact S2 in 'a couple of weeks time' unless she hears from him in the interim period.
6 Aug	S2's Care Coordinator has telephone contact with the Tenancy Support Worker who advises that he saw S2 two days previously and that he is much more enthusiastic and focused (S2 is proactive in dealing with the DSS paying rent etc) though he continues with Khat. The Tenancy Support Worker tells the Care Coordinator that S2 says he has not collected his Olanzapine prescription since week commencing the 14 July. He has however agreed to go to his GP's to request, and collect, a prescription. The Tenancy Support Worker is to remain involved with S2 until he feels that he has developed a good framework for managing his tenancy and budgeting. The Care Coordinator's record also states that '*S2* has received my letter'.
7 Aug – 30 Sept	There is no contact between S2 and his Care Coordinator. Between the 4th Sept and the 30th Sept. S2's Care Coordinator writes two letters to S2 during this time (4th Sept, and the 30th Sept) and one to his brother (18 Sept). She also attempts to make a home visit on the 10th and 15th of September but is unable to gain entry.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
1 Oct – 3 Nov	On the 1st October S2 makes telephone contact with his Tenancy Support Worker. The two individuals are due to meet on Monday the 6th October. S2's Care Coordinator asks the Tenancy Support Worker if he can persuade S2 to contact her. On the 3rd October S2 leaves a message for his Care Coordinator to call him. On the 6th October S2's Care Coordinator also receives a call from S2's Tenancy Support Worker. S2 had called by his office on the way to Birmingham but would not wait until the Tenancy Support Worker was available. On the same day (6th) S2's Care Coordinator also attempts to contact S2 by phone but this is unsuccessful as the phone line is dead. She also tried to contact S2's GP surgery on the 6th to find out if S2 was continuing to collect his prescriptions for Olanzapine. There was no response to this call.
4 Nov	S2's Care Coordinator makes a home visit to see S2. At this visit S2 agrees that he would like to challenge his Khat and Alcohol use. The records show that his Care Coordinator makes contact with The Black Drugs Project about S2. The Project agreed to visit S2 the following day. The records also show that S2 was interested to speak to Sheffield College link worker. His Care Coordinator said that she would chase this up. She also discusses 'timeline work' with S2 which the records state that he agreed to.
11 Nov	S2's Care Coordinator makes a home visit to see S2. S2 was noted to be chewing Khat and was illustrating 'pressure of speech'. There was some evidence of delusion. S2 revealed that 'he was at risk of being assassinated by the Somali Government'. S2 also told his Care Coordinator about his activist activities. S2's Care Coordinator also provided him with a letter he requested to enable him to gain a passport to visit Somalia.
27 Nov	S2 was arrested following his causing damage to property with a hammer.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
2 Dec	S2's Care Coordinator visits S2 at home. At this visit S2 told his Care Coordinator that he would like to kiss her 'if *she* was not his worker'. He also showed the Care Coordinator a letter, S2 could not explain the letter but it included the name of the manager from a local Citizens Advice Bureau. The records show that S2 told his Care Coordinator that he was going to London to visit a friend in hospital. He also spoke of a letter from the Home Office sent to him in 1995 that makes him frightened of the police. Because of this he will contact his Care Coordinator every morning. He also spoke about targeting a police officer from Somalia when he is in London. The Care Coordinator writes: "I questioned what he meant by target in a cautious way feeling at risk and uneasy myself. I got the impression that S2 meant to endanger this person. S2 presented as extremely paranoid and suspicious and felt like he's being watched and followed." S2 also told his Care Coordinator that he had smashed up a flat with a hammer (27th Nov) and that he had been arrested by the police. When asked if he was taking his medications the records say "he implied that he had". Following this meeting S2's Care Coordinator made contact with the Custody Sergeant at a local police station. During the conversation with the Custody Sergeant the Care Coordinator communicated S2's Mental Health needs and her role. S2's Care Coordinator also made contact with S2's Consultant Psychiatrist, an Approved Social Worker, S2's Tenancy Support Worker, S2's brother. The plan at this time (as documented) was for a Mental Health Act Assessment on the 5th December (Friday).
5 Dec	There is a team meeting to discuss the plan regarding S2. The notes in the medical records are relatively sparse regarding the content of this meeting. A fulsome account is documented in the Care Coordinator records. This reveals that S2's Consultant Psychiatrist; ❑ did not want to use the Mental Health Act unless he absolutely had to. The words in the records are 'not looking to use mental health act', ❑ felt that the police should deal with S2, ❑ that S2's brother could be asked to care for S2 if he does not want him to engage with Western Medicine.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
5 Dec Cont…	S2's Care Coordinator expressed her continuing concerns, namely that; ❑ S2 didn't know why he had damaged a property with a hammer, ❑ that S2 had not engaged well with her therefore there had been no opportunity to assess his mental state, however she believed he illustrated deterioration since her last visit to him, ❑ that she believed that as a mental health service they had a responsibility to determine whether S2's mental state was responsible for his current violent behaviour, ❑ that her records show that S2's behaviour is following some of the patterns prior to his last deterioration in November 2002. That is, paranoia, feelings of being watched, suspicion, aggression towards others. The Care Coordinator notes state that S2's Consultant Psychiatrist wanted her to make a decision about what to do. The Care Coordinator however felt that the Consultant Psychiatrist should take the information she had provided and make his own assessment of S2. The notes state that the Consultant Psychiatrist's response was that 'he couldn't possibly do this with patient he worked with." The outcome of the meeting was that the Consultant Psychiatrist confirmed that he would not be making an assessment of S2 and would be depending on the good judgement of the Care Coordinator. The situation was appropriately discussed with the West CNS Team Leader who subsequently met with S2's Consultant Psychiatrist. No resolution to the seeming impasse between the professionals was achieved. S2's Care Coordinator made three attempts to contact S2 and his brother on this day. She also made a home visit with an Approved Social Worker but could not gain access to his home. A message was therefore left for S2 that she would call again on Monday at 10.30am. The Care Coordinator also made contact with the CAB and left a message for the worker named in S2's letter about his deterioration and need for caution if he came to the CAB office. The Care Coordinator also makes contact with S2's Tenancy Support Worker. This individual and the Care Coordinator agree to make a joint visit to see S2 the following week. A call to S2's GP surgery reveals that he has not collected a prescription for his Olanzapine since the 5 November. However he has requested a prescription for December which the surgery said was now ready for collection. The Out of Hours Team was also advised of the situation and a fax sent to them.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
8 Dec	S2's Care Coordinator agreed with the West CNS Team Leader that she would try and see if S2 would accept an increase in his Olanzapine dose. The Care Coordinator also checked to see if S2 had collected his prescription. She was informed that there was nothing waiting to be collected so it was assumed that he had been in to collect the one which was ready on the 5th December. S2's Care Coordinator also advises the West CNS Team Leader that while she is prepared to remain involved with S2 she will not visit him again unless she is accompanied by a male colleague. The person from the Citizen's Advice Bureau (CAB) named in S2's letter viewed on the 2 December makes contact with the Care Coordinator. She is advised of the current situation and advised to have no contact with S2. This individual tells the Care Coordinator that S2, in her opinion, was showing signs of mental ill health in 1998 when he worked for the CAB. S2's Care Coordinator also tried to make contact with the Black Drugs Project but this was unsuccessful. She also made three attempts to contact S2 all of which were unsuccessful. She also tried on two occasions to contact S2's brother but this too was unsuccessful.
9 Dec	S2's Care Coordinator tries to visit S2 at home. She is not able to gain access. The Care Coordinator puts a message through S2's door and telephones S2's brother. He informs the Care Coordinator that he has seen S2 but did not really see any problem with him. He told the Care Coordinator that if she makes 'contact with him she'll make him lose his confidence'. The records show that the Care Coordinator persists in explaining her concerns about S2 to his brother and her responsibility to help S2 stay well. The outcome of this discussion is that S2's brother agrees to tell S2 that his Care Coordinator would like to speak with him. The Care Coordinator also makes contact with S2's Consultant Psychiatrist and advises that S2's Olanzapine may need increasing.
10 Dec	S2's Care Coordinator makes contact with the 'charge office' and advised that if S2 attends for his court hearing on the 13th that he is assessed by the psychiatric nurse in the court diversion team. She also tried to telephone S2 at 15.30hrs but gets no reply.
15 Dec	The Court Diversions and Liaison Nurse calls S2's Care Coordinator and leaves a message for her to make contact regarding an update on S2. (This day is a Monday)
17 Dec	S2 fails to attend for his court hearing regarding the property damage. A warrant is made for his arrest.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
19 Dec	S2's Care Coordinator speaks with the Court Diversion and Liaison Nurse. This individual advises that S2 did attend the charge office on the 13th but not the court on the 17th and there is now a warrant for his arrest without bail. The Court Diversion Nurse advises the Care Coordinator that he was not able to assess S2 on the 13th as it was a Saturday and their service only operates Monday to Friday. S2's Care Coordinator makes telephone contact with S2. He tells her that he has the flu and did not go to London. He agreed that he was Paranoid the day his Care Coordinator came to visit him (2 December). This was because 'he was drunk'. S2 'says he would like more Olanzapine'. The Care Coordinator agrees with S2 that she will make a home visit at 17.10hrs the same day with a colleague. (The Team Leader for West CNS). At the home visit S2 presents himself appropriately, and shows remorse for his behaviour on the 2 December. S2 is advised at this time that a new Care Coordinator will be assigned to him but that his current Care Coordinator will continue to be available by phone if he needs to contact her. At this visit S2 displays no evidence of mental health disorder. His non-attendance at court is discussed and he is encouraged to attend the warrant office the following day at 9am. S2's Care Coordinator also contacts the Court Liaison Service and advises them of the home visit and that his mental health is good.
7 January	The next recorded contact regarding S2 is from the Tenancy Support Worker who advises S2's Care Coordinator that as S2 has not responded to his efforts to engage he has one week left to contact them otherwise they will have to close his case file. It is also confirmed that a warrant for S2's arrest remains active. S2's Care Coordinator makes contact with the warrant office at the magistrate's court and confirms that a warrant is still out for S2's arrest. She also leaves a further message for the Black Drugs Project.
13 January	The Black Drugs Project makes contact with S2's Care Coordinator. She is advised that the Project has not been able to make successful contact with S2. The Project Worker is informed of the recent course of events. On this same day S2's Tenancy Support Worker also makes contact with S2's Care Coordinator. He informs her that he tried to visit S2 at home but there was no reply. Notably S2's TV was on and the window was open. The Tenancy Support Worker advises the Care Coordinator that he does not have the telephone contact details for S2's brother.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
13 January cont…..	S2's Care Coordinator tries to make contact with S2's brother on three occasions but is unsuccessful. She also tries to contact other family members but this too is unsuccessful. The numbers she had were either no longer in service or no one picked up the call. The Care Coordinator also discusses the situation with a senior colleague in her team.
14 January	S2's Tenancy Support Worker confirms with S2's Care Coordinator that he was going to visit S2 again on this day with a colleague. A Housing Officer also makes contact with the Care Coordinator as one of his colleagues is at S2's flat. All risk issues are explained. The Housing Officer advised that they are likely to call the police to gain access to the flat. The Tenancy Support Worker advises the Care Coordinator that this action is taken. It is also noted ion the records that the Team Leader for West CNS confirms that the new Care Coordinator for S2 has been identified. S2's current Care Coordinator makes contact with the Court Diversion and Liaison Team and leaves a message asking them to get in contact with her.
19 January	S2 is assessed by the Court Liaison and Diversion Team following his arrest on the 18th January at 14.50hrs. S2 was charged with criminal damage in a 'Garage'. He had asked the attendant for a plaster then he started breaking the displays up. At the time of his arrest, S2 was also on a warrant for arrest for a previous offence of criminal damage. At this time S2 admits that his drinking is a problem and he also admitted to chewing Khat. During interview S2 is noted to be pleasant with good eye contact. He describes his mood as 'worse than normal' stating that he is depressed. The Court Diversion notes say that 'S2 has insight into hallucinations in the past. Admits to "nasty feelings" last month. Denied them during the interview'. S2 also told the Court Diversion Nurse that 'some people were talking to him through the T.V. last month. It is not happening now.' S2 also denies any violent thoughts towards others.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
19 January cont…….	The Court Diversion record states 'There was no evidence today of any psychotic phenomenon. S2 has a diagnosis of Schizophrenia and is known to his Care Coordinator. She confirmed that at her last meeting with S2 there was no evidence of any psychotic phenomena.' (note: This was on the 19th December). The outcome of the assessment was that S2 was to attend court on the 26th January 2004. On this same day a letter is sent to S2 by his Care Coordinator advising him of the name of his new Care Coordinator and that she would like to introduce him to S2 on the 26th January at 10.30am.
23 January	S2 attends the council offices to settle the damages he had caused to the window in his flat. The Housing Officer reports that he appeared reasonable but did say that he loved her just before he left.
26 January	S2 is arrested following a double assault on a 'random passer by'. A worker from the Central Housing Team and a colleague were witness to the attack and called the police. S2 was assessed by the Police Forensic Examiner that evening and released following a telephone call to an in-patient ward at Sheffield Care Trust. The Forensic Examiner was advised that there was no record of S2 having contact with the Mental Health Service. S2 was subsequently released. **Other events:** S2's Care Coordinator tries to make contact with S2 but his 'phone is dead'. The purpose of the attempted contact was to advise S2 that the planned home visit was to be postponed as his new Care Coordinator was off sick. At this time she is unaware of the attack on 'the passer by'. S2's Care Coordinator makes contact with Housing Officer [2] and advises her that the outcome of the Court Diversion and Liaison assessment on the 19th January is that there is 'no evidence of psychosis'. Housing Officer [2] confirms that 'neighbour disturbances re: noise continuing' and that she will be issuing a warning to S2. Housing Officer [2] also advises S2's Care Coordinator that S2 attended Harden House on the 23rd January and the circumstances of this.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
30 January	The Care Coordinator records are written in such a way that they give the impression that S2's assault on a random passer by occurred on this day. However the 30th was the day that the Care Coordinator had knowledge of the assault following a telephone call from Housing Officer [2]. Following the transfer of information S2's Care Coordinator makes contact with; ▪ S2's GP Surgery and learns that he has not collected his Olanzapine prescription since the 5th November 2003, ▪ the Team Leader for West CNS and agrees an immediate home visit to drop off Olanzapine for S2, ▪ the Court Liaison and Diversion Service. When S2's Care Coordinator and the Duty Worker attended at S2's flat they found all windows boarded up except the narrow one by the door. The Care Coordinator could see a letter she'd previously sent to S2 on the window ledge. Written on this were the words "every last drop of blood is political". The records also state that there were smudges of blood around the edges of the letter. S2's Care Coordinator (and Duty Worker) left S2 a note asking him to take his Olanzapine and to contact his GP. The Care Coordinator records state "suspect he may be relapsing". While at the premises one of S2's neighbours approaches the Care Coordinator and Duty Worker and tells them that he is very concerned about the fire risk S2 poses. The neighbour is concerned that S2 will leave the gas on the cooker. The Care Coordinator also contacts S2's Consultant Psychiatrist who says he will 'chase up' S2's notes next week and that a MHA Assessment might be a consideration. The Care Coordinator also contacts the Out of Hours Team by phone and fax. The Out of Hours Team suggests a 'safe and well check' by the police over the weekend.

Community Care: 7 March 2003 – 2 February 2004

Date	Event
2 February	There is a meeting between S2's Care Coordinator, the incoming Care Coordinator, S2's Consultant Psychiatrist, a Clinical Psychologist and the Team Leader for West CNS. The outcome of this meeting was that the team did not think they were 'at the point of completing a Mental Health Act Assessment' as S2 was continuing to display periods of rationale lucidity amongst periods where he was drunk or high on Khat. The records suggest that the persons present were aware that S2 did present a high risk but that his current Care Coordinator and newly appointed Care Coordinator should continue to gather information. These two professionals agreed to visit S2 again on the 4th February. At 16.30hrs on the 2nd February the Team were advised that S2 had been arrested on suspicion of arson following an incident where a person had died.

CHAPTER FOUR

OTHER LEARNING OPPORTUNITIES IDENTIFIED BY THE INVESTIGATION TEAM DURING THE INVESTIGATION OF THE CARE AND MANAGEMENT OF S1 AND S2

1.0 Introduction: Other issues identified by the Investigation Team during the course of the investigation

As part of the analysis of the systems and processes designed to deliver safe and effective services to Mental Health Service Users in Sheffield a semi-structured questionnaire was issued to 60 members of staff currently working within the Younger Adult Service at Sheffield Care Trust (SCT). Thirty of these were distributed across the four Acute In-Patient Wards and thirty across the four Community Mental Health Teams. The areas explored within the questionnaire were:

- CPA and Risk Assessment
- The Mental Health Act and Section 17 Leave
- Cross Service and Cross Agency Working
- Families and Carers
- Interface with the Local Police Force
- The weekly Team Meeting – targeted specifically to the Continuing Needs Service
- Management Supervision
- Clinical/Professional Supervision

In addition the managers of the four Acute Inpatient Wards, Sector Teams and Continuing Needs Service were asked to seek the views, opinions and experiences of Risk Assessment Training from five of their staff. To ensure consistency of questioning and data collection each manager was provided with a standardised A4 template for collecting the information.

The response rate from front line staff was excellent with a return rate of 61%. The response rate from ward and team managers was 40%.

Whilst it is not appropriate to provide the full detail of the analysis of the questionnaires within this report salient findings have been included.[33]

In addition to the questionnaires the staff interviewed shared helpful information the themes of which mirror those of the questionnaire.

[33] The report detailing the full analysis of the questionnaires is available upon request.

1.1 CPA

By and large the staff interviewed did appear to be committed to the principles of CPA and generally gave the impression that the practice of CPA had improved over the last number of years with:

- Consultants having dedicated diary time for CPA Reviews that other CMHT members could book out for Mental Health Service Users.
- CPA Secretaries having been appointed to each CNS to support staff with data entry, ensuring that the paperwork is complete and that following a CPA Review the date for the next Review has been agreed and documented. 67.6% (25) of respondents to the questionnaire specifically stated that the CPA Secretary either booked the next Review date, or recorded the date and sends a reminder.
- Regular information is sent to Team Managers regarding outstanding CPA Reviews by the CPA Coordinator.
- Designated CPA training for Care Coordinators.

The questionnaire analysis revealed that

- 89% of respondents 'more often than not', or 'strongly agreed' that CPA meetings are usually attended by all relevant members of the health and social care team, including the Service User's Consultant Psychiatrist.
- 91.8% of respondents 'more often than not', or 'strongly agreed' that CPA care plans usually reflect a package of care that has been designed to meet the specific needs of the Service User.

However the Investigation Team also identified a range of issues that the SCT Mental Health Services for Adults of Working Age needs to reflect on:

- Only 48.6% of respondents to the questionnaire agreed with the statement "The CPA process is focused on designing and delivering the optimal care package for the Service User". 51.3% disagreed.
- The response to the statement "Service Users on Enhanced CPA who do not attend for their out patients appointment are <u>always</u> discussed at the CNS Team meetings revealed that;
    - 16.4% (6) believed that this always happened with good discussion about subsequent client management
    - 2.7% (1) believed that it always happened but the quality of discussion around client management is sometimes lacking
    - 16.2% (6) believed that discussion sometimes took place

- 24.3% (9) believed that it would not be routine for DNA's to be discussed at a Team Meeting
- 40.5% (15) did not answer the question. These non respondents are from inpatient services.

- Voluntary Sector staff engaged with a Service User are not always invited to CPA meetings. The Team Manager for the Black Drugs Project told the Investigation Team that she was not aware of any of her staff ever having been invited to a CPA Review. While the SCT CPA Policies and Procedures (2002) document does address the organisation of CPA Review meetings and says that the Care Coordinator should "Prepare Clients for CPA reviews by discussing with them who will be present" the Investigation Team are not confident that Service Users are encouraged to think about the range of persons engaged in their care and management outside of the Statutory Services as useful persons to invite to such meetings.
- The current auditing processes for CPA targets the collection of performance monitoring data and not data that enables the assessment of the standard of CPA Practice. This is something the Clinical Director of Adult Services is hopeful they can address with the newly implemented management structure within the organisation.[34]
- An analysis of the SCT's current CPA Policy revealed that;
  - there is no reference to a single or unified risk assessment (ref 1.3),
  - whilst the policy document does refer to the requirement for follow up within seven days of discharge it does not make clear who is responsible for ensuring that this follow up occurs (ref 7.12),
  - appendix three details NHS Direct and The Samaritans as 24 hour access numbers for Mental Health Service Users. The Investigation Team suggests that the Trust consider more local ownership for this appendix such as the Crisis Team Number, local support groups and the local out of hours Primary Care Service or General Practioner (GP) number.

[34] SCT is committed to embracing New Ways of Working and are in the throes of implementing a new directorate structure that puts partnership working and shared accountability between each Service Director and Clinical Director at the heart of these developments.

1.2 Mental Health Act Assessment

A key concern for the Investigation Team was the inability of the Mental Health Service to effectively contain S2 once he had been detained. Given that the sole purpose of detaining a person under Section 2 of the Mental Health Act is to undertake an assessment and determine whether or not there is a mental health illness, exploration of practice and knowledge around the Mental Health Act and detained patients was considered essential.

The questionnaires issued to staff revealed that staff have a comprehensive understanding of their responsibilities and duties to detained persons.

Staff were specifically asked what they would do if a detained client was frequently taking unauthorised leave to minimise the risk of recurrence. One response that encapsulates many of the responses given is:

"An RMO assessment as to the appropriateness of leave, i.e. absconsion no longer an issue. Plan/negotiate Section 17 Leave, escorted or otherwise. If leave is not appropriate because risks are too great or a fuller assessment is required the patient would be placed on appropriate 'safe and supportive' observations Policy. If this was felt to be too risky the doors would be locked as per unit policy".

A number of other respondents also stated that the Intensive Treatment Service would be asked to assess the Service User if the ward team felt that containment was not feasible in an open ward environment.

On the basis of these responses the Investigation Team is satisfied that staff in general have an appropriate understanding of their duties to persons detained under Section 2 of the Mental Health Act and the range of activities they should consider implementing if a Service User is challenging to detain.

For Reflection:

In the case of S2 it was difficult to ascertain from the nursing records decisions made regarding his Section 17 Leave entitlement. The respondents to the questionnaire revealed that there are a variety of places where such decisions might be recorded. Variability in the placement of such records the Investigation Team considers to be unhelpful to staff responsible for delivering care and for the effective audit of practice.

Another issue that concerned the Investigation Team was the inference in S2's records that he had been positively allowed off the ward when no Section 17 Leave had been agreed for him. Via the questionnaire issued staff were therefore asked: "On an open ward is it custom and practice to allow a detained patient <u>without</u> Section 17 Leave off the ward, or access to an unsecured area?"

- Only one respondent (2.7%) said that “I am unaware that this has ever happened”.
- Five respondents said (13.5%) that it may occur in exceptional circumstances, for example where this decision presented less of a risk than restricting them to the ward. In such circumstances the Service User may be allowed fresh air to walk around the building (classed as within the hospital).
- Eight respondents (21.6%) said that whilst it was not custom and practice to allow this it does happen.

Whilst the Investigation Team accepts that there will be exceptional circumstances that lead to breaches in policy and procedure it suggests that the new Management Team for Younger Adults Services review its current guidance on this area of practice so that staff have clear parameters of practice should they decide to allow a Service User off the ward where no Section 17 Leave has been agreed.

1.3 Supervision Of Staff

During interviews with staff the Investigation Team were able to identify that:

- Service Managers for the Sector and CNS Teams meet with the Team Managers every three-four weeks for Supervision.
- Now (2006) all Consultant staff have an appraisal. This is markedly different to the situation in Sheffield two – three years ago when the Medical Director would not have had the same degree of confidence. The Trust has a system whereby all Clinical Directors have access to key performance indicator data, complaint data, etc to assist with this.
- The Trust has made a commitment to undertaking 360 degree appraisals for consultant staff. It is notable that the Trust has made this affordable by working cooperatively with other NHS Trusts within the region. The driver for implementing such a rigorous process for its Consultant staff is a belief that it will enable an effective transition from a service model where clinicians held no operational accountability to one where clinicians will hold operational accountability.
- A number of staff commented on the value of the Senior Practioner Role for clinical and professional supervision regardless of whether their supervisor was from the same professional discipline as themselves.
- The Team Leader for West CNS was noted to be very approachable and a typical quotation was you ‘can approach him about anything’.

Notwithstanding the positive feedback and developments highlighted above the Investigation Team did receive a mixed picture with respect

to staffs current levels of satisfaction with the supervision process. This applied to Management[35] and Professional[36] Supervision.

When specifically asked about this via questionnaire:

- 54% (20) said they were very satisfied with their Supervision.
- 37.8% (14) said they were not completely or not at all satisfied with their experience of Supervision.

This contrasts with the Trust's own Survey[37] undertaken in March 2005 which revealed 95.7% (22) of their target audience said that their supervision sessions meets their needs.

With respect to Professional Supervision, staff identified its strengths as

"easily accessible, professional, documented and client focused"
"constantly available, effective and developmental"
"reflection on practice, alternative thoughts on practice, sharing time"
"time given to get things off my chest to ask advice and guidance off an experienced member of staff".

Opportunities for improvement:

A number of staff told the Investigation Team that no-one undertook any case note review as an integral part of the supervision process. Furthermore while the Investigation Team were given to understand that a process of Peer Review had been implemented to address issues such as this we were not able to elicit any evidence that this process was working effectively at the time of the investigation.

Respondents to the questionnaires made a number of suggestions for improving the process of supervision. The predominant suggestion was greater formalising of the process with a more structured approach as to how issues discussed and agreed are recorded with the supervisee being provided with a copy of the records made.

A number of staff at (interview and questionnaire) also suggested that 'regular planned caseload supervision with a Senior Practioner' would help increase the levels of transparency regarding caseloads within teams.

With specific respect to enhanced skills respondents suggested:

[35] The briefing paper for SCT's draft Supervision Policy says that "Supervision links the management of practice to the organisational task. It is a composite activity with the aims of managing the work, supporting and developing staff, ensuring quality and effectiveness. Supervision from a management perspective includes workload management, managerial advice and direction, personal/work related issues, career development and appraisal."

[36] Professional Supervision: "A process in which one worker is given professional responsibility to work with another in order to meet certain organisational, professional and personal objectives. These objectives are competent, accountable performance, continuing professional development and personal support" Morrison 1993. (Adapted from, Harries 1987 from South West Yorkshire Mental Health Trust).

[37] Supervision Audit March 2005 p3 Q4.

- The need for access to specialist supervision in areas of practice such as Cognitative Behaviour Therapy, Psychosocial Intervention.
- Listings of those able to offer supervision, including information about any specialist areas of practice.

Comment:
SCT is currently revising its Supervision Policies and particularly the ways in which Supervision can be provided to staff. The emphasis is on a more flexible model that incorporates;

- the traditional 1:1 planned and timetable meetings between worker and manager,
- peer supervision, i.e. a group of professionals coming together to discuss practice issues,
- self directed supervision, i.e. where the individual determines when they receive supervision based upon their own perceived need.

This process provides the Trust with the opportunity to build on its current strengths and reflect the improvements its staff would like to see in the way that both Management and Professional Supervision are delivered. The Investigation Team suggests that within the revision of the policy it ensures that boundaries are set that state the maximum length of time a person can go without supervision.

1.4 Risk Assessment – Training And Practice

In addition to the aspects of risk assessment practice that are directly relevant to the care and management of S1 and S2 the Investigation Team identified a range of issues in relation to the clinical risk assessment process that SCT needs to reflect on:

Positive Feedback

- There is mandatory training for Care Coordinators on Risk Assessment and Management and this is reputedly well subscribed. The intention is that all newly appointed Care Coordinators attend this training within three months of being appointed.
- The Assessment Officer for Vulnerable Persons (Mental Health) in the Housing Department at Sheffield City Council told the Investigation Team that the quality of risk information provided to her by the staff at Sheffield Care Trust is usually fulsome and appropriate for the purpose of sourcing a suitable tenancy for an individual.
- All staff the Investigation Team interviewed demonstrated a clear appreciation of the importance of the risk assessment process in the assessment and care planning undertaken with individual mental health service users.

- 41% of respondents to the survey of staff's experience of risk assessment training said that they had already attended the Dual Diagnosis Training Workshop and 20% said that they had attended the Drug Awareness Workshop.

For Reflection

- There is currently no audit of the Trust's standard that all newly appointed Care Coordinators attend Risk Assessment and Risk Management Training within three months of appointment. The Investigation Team's discussion with the current CPA Coordinator suggested that the post holder believed that this would be possible and that there would be merit in having this knowledge within the service.
- There is currently no requirement for qualified staff to attend a mandatory refresher on Risk Assessment and Management at least every three years. The absence of such a requirement runs counter to the recommendation of the 1999 National Confidential Inquiry Report 'Safer Services'[38].
- The analysis of the survey of staff's experience of risk assesment training revealed that 25% had received training more then three years ago, 33% had never received any training and a non-response rate of 25%.
- A number of staff informed the Investigation Team that they had concerns regarding the quality of risk assessment undertaken. Most prominent were;
    - that some risk assessments appear anecdotal rather than evidence based
    - data provided by the Service User can be misrepresented because the circumstance and the context of the identified 'risk behaviour' is not explored or documented in sufficient depth.
- All in-patient staff interviewed told the Investigation Team that there was a lack of clinically focused risk assessment and management training. This was further evidenced by the respondents to the questionnaire. Not one member of the in-patient services had received any risk assessment training.
- During interviews with SCT staff the Investigation Team did not get a sense that the clinically focused risk assessment was a Multi-Disciplinary activity. The respondents to the questionnaire revealed a split in the experiences of staff with 45.9% saying that the clinical focused risk assessment was a uni-professional activity and 35.1% saying that it was multi-professional.

[38] Safer Services – National Confidential Inquiry 1999 http://www.national-confidential-inquiry.ac.uk/nci/find_information/index.cfm?content_id=01F0A5BB-44E9-4DE6-A2BFA399D3A50620

- A number of staff told the Investigation Team that they would welcome further professional development in how to record risk assessment (and progress note data) more effectively with specific regard to the
    - depth of information required
    - volume of information
    - how to construct succinct sentences that convey all essential information required
    - use of language
- The Investigation Team could not identify a specific tool for documenting the clinically focused risk assessment within in-patient services. The respondents to the questionnaire confirmed that there is no such tool.
- A number of staff advised that they found the current risk assessment and management training targeted towards less experienced staff with specific focus on the completion of the Trust risk assessment documentation. Staff told the Investigation Team that a spectrum of training was required to meet the needs of more experienced staff and those working with more complex communities within Sheffield.
  Only 8% of respondents to the survey on risk assessment training said that it had a significant impact on their knowledge and understanding, however 41% said that risk assessment training was of significant relevance to their clinical work.[39]

1.5 Other Assessment Tools

During the investigation the Investigation Team gained a sense that there are a variety of tools at the disposal of the staff providing assessment and treatment to mental health service users. During a range of interviews the following were identified:

- Psychosocial Intervention[40]
- Becks Inventory[41]
- KVG[42]

There did not appear to be any common or standardised tool kit regarding the tools that the Younger Adult Service is committed to.

[39] The suggestions provided by staff regarding what they feel needs to be included in future workshops to increase their knowledge and skills will be provided to SCT Trust.

[40] Psychosocial Intervention (PSI): Include psycho educational approaches to the Service User and family and general support. Management of Service Users receiving PSI should be individualised and comprehensive. This may include social skills training (to help compensate for the negative symptoms of chronic schizophrenia), assertion training and cognitive-behavioural interventions for any drug-resistant symptoms the patient may experience. PSI also targets the Service Users Family in an effort to reduce expressed emotion and achieve reduction in the burden of care (both objective and subjective) for the family.

[41] Becks Inventory: This is a 21 item self report rating inventory which measures characteristic attitudes and symptoms of depression. Beck *et al* 1961.

[42] KVG: This is a Psychiatric Assessment Scale (also known as the Manchester Symptom Scale) designed for use with persons with Schizophrenia or Schizoaffective disorder who hear voices.

What was clear is the considerable investment that has been made within the teams of the Ward Manager and CNS Team Leader that the Investigation Team interviewed in Psychosocial Intervention Training. The training available to staff is at a range of levels, foundation, certificate and diploma. Two of the managers interviewed advised that they either had, or were working towards achieving a 'critical mass' of staff who are trained in PSI, who can then offer this approach to care with the persons on their caseload.
This commitment to developing this range of skill within specific teams is laudable but the Investigation Team is concerned that the commitment to training staff in PSI is not supported by

- any competency assessment framework
- an appropriate supervision structure.

1.6 Operational Policy – Continuing Needs Service

The Operational Policy for a service, team or department, is central to team functionality and the rules and regulations of practice. The Operational Policy for the CNS that was provided to the Investigation Team was developed when the CNS was being set up. Its intention was to make clear the resources required. Now that the CNS is fully established the CNS needs to revise its Operational Policy so that it reflects current standards and provides clear direction to the teams so that parity can exist across the service.

CHAPTER FIVE

OVERALL CONCLUSIONS AND RECOMMENDATIONS OF THE INVESTIGATION TEAM

1.0 SUMMARY OF MAIN FINDINGS

The following sets out a summary of the main findings of the Investigation Team following its analysis of the care and management of S1 and S2.

1.1 Positive Feedback S1:

- Throughout his contact with Mental Health Services S1 was appropriately transferred from Acute Adult Inpatient Services to more secure care environments when he was displaying behaviours that put himself and others at a level of risk that could not be managed in an 'open ward' environment.
- In February 2001 the Team Leader for the then North Continuing Needs Service proactively liaised with the South Yorkshire Housing Association to agree in principle funding from the Community Care Purchasing Panel so that S1's discharge from the Sheffield Low Secure Unit was achieved safely.
- In recognition of the challenge and complexity S1 presented, co-working was offered to his Care Coordinator in March 2001.
- The information exchange between the Medium Secure Service in Nottingham and the Acute Inpatient Service in Sheffield was excellent. (2002)
- S1 was assigned a culturally appropriate Care Coordinator in May 2001 who co-worked with his previous key worker. S1's new Care Coordinator had Sheffield Out Reach (SORT) experience that enabled a flexible model of contact to be instituted and sustained with S1.
- In spite of the challenges of confidentiality S1's Care Coordinator between April 2001 to the incident date tried to meet the needs of S1's mother without breaching his duty of confidentiality to S1 who did not want any information shared with her.
- S1 was appropriately challenged regarding the appropriateness of his relationship with a minor with whom he fathered a child. (The Mental Health Service became aware of this relationship in October 2001. The relationship did not last and had terminated by the end of April 2002).
- The clinical records evidence communication and cooperation between the Mental Health Workers involved with S1 and the social workers working with the mother of S1's child.

1.2 Issues of Concern S1

Initially the Investigation team had three main areas of concern regarding S1's care and management. These were:

- The circumstances surrounding his discharge from the Low Secure Unit on the 9th April 2001 and the non-availability of a Consultant Psychiatrist to take ongoing responsibility for him.
- His apparent discharge from Section 3 of the Mental Health Act on the 24th January 2002 without a mental health state assessment.
- The lack of knowledge within the Mental Health Service that S1 had not been to collect his prescription for approximately eight weeks prior to his deterioration and subsequent admission to hospital on the 24th July 2002.

1.3 Main Conclusion S1

The subsequent analysis of S1's care and management allayed all concerns about his care and management bar the issue of the interface between Mental Health Services and Primary Care regarding medication compliance. The Investigation Team concludes therefore that S1's care and management met the standards one would expect and was therefore reasonable.

1.4 S2

Positive Feedback S2:

- Appropriate action was taken when S2 went absent without leave (AWOL) from the in-patient ward after threatening to burn down the housing complex where he lived prior to his admission to hospital.
- S2's Care Coordinator was instrumental in ensuring that S2 was not discharged as homeless from the in-patient ward.
- Whilst S2's Care Coordinator did struggle to effect a therapeutic relationship with him she was diligent in her efforts to provide support to him as far as she was able.
- Stringent efforts were made by S2's Care Coordinator to seek the advice of senior colleagues in the management of S2 between early December 2003 and 2 February 2004.
- The Tenancy Support Worker at Shelter provided an excellent level of service to S2.
- The Team Leader for West Continuing Needs Service undertook to assess S2 himself following an impasse between S2's Care Coordinator and his Consultant Psychiatrist.

1.5 Issues of concern S2

1. The period of time S2 was detained under Section 2 of the Mental Health Act did not result in an effective assessment of his mental health state and consequently there was uncertainty and ambivalence regarding his diagnosis.

2. S2 was not actively engaged in the management of his mental health needs following his discharge to the West Continuing Needs Service in March 2003.
3. Between December 2003 and February 2004 there were two occasions where S2 should have had his Mental Health State assessed with a view to offering him an informal admission or detention under the Mental Health Act. Although S2's Care Coordinator, the Team Leader for the West Continuing Needs Service and S2's Consultant Psychiatrist were engaged in discussions regarding what action to take, and the appropriateness of a MHA assessment, on neither occasion was such an assessment initiated.

1.6 Main Conclusions S2

Although there were many positive aspects to S2's care and management by the Mental Health Service provided in Sheffield the Investigation Team believes that the standard of service offered to him fell below the standard one would expect at three specific stages of his contact with the Mental Health Service:

- The period of his compulsory admission to hospital commencing in November 2002.
- The lack of assessment of S2's mental state by his Consultant Psychiatrist in December 2002 when S2's Care Coordinator voiced her concern that S2 may be relapsing.
- The lack of any assertive attempt to assess S2's mental state between the 22nd January 2004 and the 2nd February 2004. Although one cannot predict the outcome of such an assessment the Investigation Team believe it probable that such an assessment would have resulted in the compulsory admission of S2 prior to the date of the incident.

2.0 CONCLUSIONS SPECIFIC TO THE TERMS OF REFERENCE FOR THIS INVESTIGATION

1. In relation to the appropriateness and quality of treatment (S2):
    - That the risk assessments undertaken were insufficient and did not detail any risk management plan if S2 presented with any of his relapse indicators.

    - There was little appreciation of the influence of S2's cultural background and his inability to engage with the Mental Health Services.

    - In the period leading up to the incident of arson (5th December 2003– 30th January 2004) there was a lack of correlation between S2's presenting features at this time and those featured when he was detained under the Mental Health Act in November 2002.

    - Although there were understandable reasons why no CPA Review was undertaken for S2 between the 16th January 2003 and the 4th February 2004, this omission was contrary to what was planned, national guidelines and local policy.

    - Whilst S2's Care Coordinator made a sustained effort to engage S2, the involvement of the Transcultural Team and the advice of the Sheffield Out Reach Team may have resulted in a more appropriate and flexible model of care.

    - With the exception of the Somalian Mental Health Project communication with the range of agencies involved in the provision of care and services was largely appropriate. However the Investigation Team suggests that S2's Care Coordinator should have created opportunities for the relevant agencies to have come together to discuss S2's care and management.

    - S2's Care Coordinator made sustained efforts to engage with S2's family, in particular his brother. That S2's brother did not engage with this individual is no reflection on this Care Coordinator.

2. In relation to the appropriateness and quality of treatment (S1):
    - The Care Coordinator for S1 employed an appropriate model of care to maximise the opportunity for engagement by S1 with the Mental Health Service.

    - The Care Coordinator for S1 appropriately managed the complexities of the relationship between S1 and his mother.

3. In relation to Service Management:
    - The current Operational Policy for the Continuing Needs Service is out of date and does not meet current expectations of an Operational Policy.

    - SCT does not provide any risk assessment training to its in-patient staff. Neither does it require its community staff to attend refresher training on an at least a three yearly basis. This is unacceptable.

3.0 ACTIONS AND DEVELOPMENTS TAKEN TO DATE BY THE MENTAL HEALTH SERVICE IN SHEFFIELD

Since the incidents involving S1 and S2 a number of developments have occurred within the Younger Adults Mental Health Service in Sheffield that address some of the concerns identified within this, and the SCT's own internal investigations following the incidents. These actions are:

The development of a Dual Diagnosis Policy and Training Programme.
This programme has been developed in recognition that there are an increasing number of Mental Health Service Users who have both significant mental health needs and also substance misuse issues. The programme recognises that there is a tendency amongst mental health staff to overly focus on substance misuse issues at the expense of the mental health need.

In addition to the 'in-house' workshops the service is committed to investing in an external five day training workshop for 20 staff in the financial year ended the 31st March 2007.

Conflict Resolution
A significant issue identified by the internal and external investigation into the care and management of S1 and S2 is the management of apparently irreconcilable clinical disputes. As a result of the service's internal investigation into S2 the West Continuing Needs Service committed itself to developing a process to enable better conflict resolution in the future. This work has now been embraced as an Adult Services wide governance project.

The development of a Adult Mental Health Services Personal Information Sharing Procedure under the South Yorkshire Multi-Agency Information Sharing Protocol (Mental Health Issues)
This protocol sets out the client information sharing processes between:

Sheffield Care Trust – provider of integrated Adult Mental Health Services and

Sheffield City Council (Neighbourhoods and Community Care Directorate) – provider of services to homeless people and housing and

Sheffield Homes Ltd – provider of housing.

The protocol provides clear guidance regarding the information that is expected to be shared between the services and the principle that SCC staff will be invited to CPA meetings, or at least have the opportunity to feed information into these. The protocol also provides staff in all the

services with clearly identified contact points in each service for progressing and difficulties or concerns.

Operational Management of Adult Services

Since coming into role as Medical Director, the post holder has sought new structures that integrate clinicians into the management structures of the organisation. This is now reaching its implementation phase with a directorate management structure that means that the responsibility, the running, and the quality of the service provided within each directorate will be shared by a practicing clinician and a full-time manager. The practicing clinician will work half the time in their Clinical Director role with their clinical time being 'back filled'. These developments have resulted in the appointment of three Clinical Directors to cover what was previously the Adult Care Group.[43] This was a service area that previously had one Clinical Lead.

[43] One Clinical Director for Adult In-patient and the Community, one Clinical Director for Rehabilitation and Recovery, One Clinical Director for Substance Misuse.

4.0 RECOMMENDATIONS

Priority Recommendations

These represent the most important, and pressing, pieces of work the Investigation Team believes SCT and the Mental Health Service for Adults of Working Age need to consider and address, to ensure that the robustness of the systems and processes designed to deliver a safe and effective mental health service to the population of Sheffield are achieved.

Secondary Recommendations

These represent additional work that the Investigation Team would encourage SCT to consider but which should not take precedence over the priority recommendations.

Priority Recommendation 1:
The West Continuing Needs Service has commenced work to agree a draft protocol/pathway for managing clinical disputes but the status of this project needs to be elevated so that it is adopted as an Adult Services wide project with defined timescales and deliverables that are monitored by the Trust or Service Governance Committee.

Whilst there remains some contention about S2's Consultant Psychiatrist's refusal to undertake an assessment of S2 on the 5th December 2002, the questionnaire response provides firm evidence that there is no escalation pathway that can be used by staff within the Service for Adults of Working Age where issues of clinical dispute/concern arise that do not respond to local resolution.

The current programme of work being undertaken appears to be very specific to the West Continuing Needs Service and this is no longer appropriate. A working party representative of the teams and professionals working within the Service for Adults of Working Age that reports to the Service Director and Clinical Director needs to be commissioned.

In commissioning this work the Management Teams for the Service for Adults of Working Age, specifically the Service Manager and Clinical Director for the Directorate of Rehabilitation Recovery and Specialist Mental Health, need to ensure that there are:

- Agreed terms of reference/objectives.
- Agreed timescales for delivery for each phase of the project.
- Clarity as to who is taking the project lead.

Note 1: The Investigation Team believes that it is essential that the profile of this work is raised so that the evolution of the pathway can rise above the specifics of individual practioners.

Note 2: The Investigation Team believes that the development of an escalation of concern model must be rolled out organisation-wide once its prototype has been agreed and tested.

Target Audience:
The Executive Director for Mental Health Services for Adults of Working Age.

The Clinical Director for the Directorate of Rehabilitation, Recovery and Specialist Mental Health Services.

The Service Director for the Directorate of Rehabilitation, Recovery and Specialist Mental Health Services.

The Team Leader for West CNS.

Priority Recommendation 2:
SCT needs to undertake a number of developments in relation to the clinically focused risk assessment process and training delivered to its staff.

The cases of S1 and S2 highlight the central importance of the clinically focused risk assessment to the delivery of an effective Mental Health Service. The analysis of the care and management of these patients and the questionnaire responses provided to the Investigation Team clearly indicate that SCT's current approach to training and practice needs to be revised.

Specifically the Investigation Team recommends that:

- With immediate effect the Trust makes its current risk assessment training programme available to its in-patient staff.
- The Trust implements a unified baseline risk assessment documentation tool for in-patient and community use as soon as possible. The Trust may wish to consider incorporating two specific subsections for in-patient and community use to accommodate the differences in the risk assessment process between these two areas of the service. Regardless of the design of the risk assessment form, to continue with the current situation is untenable.
- The Trust must make provision in the financial year 2006/2007 and annually thereafter, for the delivery of refresher training in the clinically focused risk assessment every three years to its entire cohort of qualified staff.

In the medium term the Trust is encouraged to:

- Take note of the feedback provided by its staff to this Investigation Team regarding the need for a graduated training programme in the clinically focused risk assesment. Staff currently find the programme geared to the needs of the inexperienced practioner.
- If the Trust does expand the training opportunities in risk assessment for its staff the Investigation Team encourages the Trust to incorporate;
    - opportunities for staff to explore different ways of documenting their findings. Exploration of the
        - depth of documentation required
        - the volume of information required
        - how to construct succinct sentences that convey the intended message
        - the use and non-use of language

      these were all issues that SCT staff highlighted as issues they believed would enhance their documentation of risk,

- the importance of exploring and documenting circumstance and context of identified risk behaviours with Service User,
- the process of Peer Supervision as an opportunity for reflection and analysis on the quality of risk assessments undertaken and the quality of the documentation around this.

- Review and streamline the range of additional assessment tools, such as KVG and Becks[44] that are currently in use across Adult Services. In addition to ensure that all staff using these tools have been appropriately trained and receive appropriate supervision.

Target Audience:
Executive Director of Adult Mental Health Services
SCT's CPA Coordinator
Service Director for Acute and Community
Clinical Director for Acute and Community
Service Director for Rehab and Recovery
Clinical Director for Rehab and Recovery

[44] Becks Inventory: This is a 21 item self report rating inventory which measures characteristic attitudes and symptoms of depression. Beck *et al* 1961.

KVG: This is a Psychiatric Assessment Scale (also known as the Manchester Symptom Scale) designed for use with persons with Schizophrenia or Schizoaffective disorder who hear voices.

Priority Recommendation 3:
SCT must establish the baseline information essential to the effective assessment of Service Users detained under the Mental Health Act. In identifying this SCT must ensure that its practice is commensurate with any relevant National Guidance and good practice standards.

It is the opinion of this Investigation Team that had S2 received an effective assessment during the period of his initial detention and hospitalisation between 11th November 2002 and the 7th March 2003 then there would have been clarity regarding his diagnosis and clarity regarding the influence of drugs and alcohol on his mental health state. Furthermore staff would have known whether or not his episodes of psychosis were purely generated by his substance misuse or merely exacerbated by this. Clarity about this may have significantly affected the attitude of S2's Care Coordinator, S2's Consultant Psychiatrist and other members of the team to S2's decline from December 2003.

At minimum the Investigation Team recommends that the Directorate for Acute, Community and Primary Care Mental Health Services undertakes a case note audit of a percentage of Service Users who have been detained under the Mental Health Act to ascertain:

- How many of these have a clearly documented diagnosis at the end of their period of compulsory admission?
- How many had a clearly defined and documented management plan?
- The frequency with which Service Users present significant challenges to containment for in-patient staff and where no referral is made to the Intensive Support Services.

Based on the output of such a specific and detailed practice analysis the Adult Service will have a more precise picture of

- whether there are development needs for staff in the care and management of these clients
- whether these issues need to be addressed within the Services Operational Policy for Inpatient Services
- whether there is merit in periodic audits of this issue.

With regard to timescales this is an audit the Investigation Team suggests is planned for the current (2006/2007) financial year.

In addition to the above the Investigation Team suggests that SCT requires staff to document Section 17 Leave on its formalised template rather than the seemingly ad-hoc approach to documenting this that the investigation found. Streamlining of this aspect of practice will enhance the Trust's ability to audit Section 17 Leave practice.

In addition
For Action within Six Months
As an integral part of the Trust's patient safety commitment the Investigation Team believes that the Directorate of Acute and Community and Primary Care Mental Health Services must ensure that its staff are aware of the inherent risk in allowing a patient detained under the MHA to leave the ward or the secure garden area, where no Section 17 Leave has been agreed. This could be accommodated within the Trust's existing Mental Health Act training.

The Investigation Team appreciate that there will be occasions where a staff member may consider allowing a detained patient time 'off the ward' to be an appropriate risk decision. In such circumstances it is critical that the rationale for this decision is clearly documented in the contemporaneous record.

For consideration:
The Investigation Team noted that the current Mental Health Act Administrator is well qualified in her field yet she has no active involvement in the education and training of mental health professionals in the understanding and use of the MHA. The Trust may wish to consider how it can maximise the benefit of this resource in the future education of its staff.

Target Audience:
Executive Director of Adult Mental Health
Service Director for Acute and Community
Clinical Director for Acute and Community
Service Director for Rehab and Recovery
Clinical Director for Rehab and Recovery

Priority Recommendation 4:
The Operational Policy for the CNS Service needs to be updated so that it becomes a valuable and practical document for staff.

During the investigation process the Investigation Team identified that the current Operational Policy for the Continuing Needs Service is not fit for purpose. Given the central importance of this document to the overall good functioning of individual practioners and the team the Investigation Team believes that addressing this should be a priority for the service.

An effective Operational Policy should;

- inform the practioner of the purpose of their role
- inform the practioner of the expectation of them within the service/team
- direct the philosophy and approach to care
- guide the practioner to particular policies and other services and agencies with which they are expected to interact.

At minimum such a policy would therefore be expected to address the:

- Clear definition of the clinical and managerial leadership.
- Clear definition of the roles and responsibilities of individual team members (to include clarity of differentiation between the grades of CPN).
- Case load allocation and case mix (e.g. 70% on Enhanced CPA 30% on Standard CPA).
- Collective caseload size for each CNS and the maximum case load for each 'member' type
- The CNS's relationship with General Practioners (e.g. on a quarterly basis one or more of the CMHT members will meet with the GP practice to look at issues of concern, referral patterns etc).
- Systems for preceptorship and induction of new staff (to include how different grades of staff are managed and supported).
- The model of Supervision if SCT decides to allow this to be agreed on a team by team basis.

In addition to the above the Investigation Team recommends that a revised operational policy includes clear guidance for staff on engaging with Service Users from Black Minority and Ethnic Communities. It is expected that this guidance will detail:

- The range of internal and external resources available to support effective engagement with Service Users.
- Recommended communication pathways.
- The location of more detailed information about specific internal and external resources including the terms of engagement for external statutory and non-statutory agencies.

Note: This recommendation may have relevance across a range of other services within the Mental Health Service in Sheffield. The Investigation Team encourages the Trust to ensure that all Service Directors and Clinical Directors have sight of this so that they can benchmark their own Operational Policies against the principles espoused.

Target Audience:
Executive Director for Adult Mental Health
All Service Directors and Clinical Directors working within Adult Services, including Rehab and Recovery.

5.0 SECONDARY RECOMMENDATIONS:

In addition to its principal recommendations the InvestigationTeam encourages that:

CPA

- Where multiple agencies are engaged in supporting a Service User then early consent is sought for involving these persons in CPA. Also CPA process must ensure that it supports the involvement of the multi-agency parties in the CPA process. If INSIGHT does not already accommodate the recording of other agencies involved with the Service User incorporation of the facility for this may be useful.
- The current system for alerting Team Managers to overdue CPA Reviews is enhanced with the CPA Coordinator having invested authority to ask for the reason for delayed CPA Reviews and to raise any ongoing delay with the Directorate Manager and Clinical Director.
- Data on delayed CPA Reviews, including the reasons for any such delay, is incorporated into the existing audit process for CPA. The analysed data should be made available to each CNS for discussion and action planning at their respective Service Governance Meetings. The aggregated data should also be presented at the Service Governance forum for the Directorate of Acute and Community.

- Amend Appendix three to the Trust's current CPA policy (see page 83 of this report).

Clinical Records

- While SCT were able to evidence that an audit of medical documentation had occurred there appears to have been no audit of the quality of documentation across all professional groups. Given the issues identified regarding the quality of documentation in the case of S1 and the information shared with the Investigation Team at interview it is recommended that;
    - a designated audit tool is developed to support the peer review of clinical records. Issues that might be encompassed within such a tool are i) does the care plan reflect the needs of the patient and set out clearly the intended management plan? ii) is there a clearly documented risk containment and contingency plan? iii) do the progress records contain a clear and accurate description of the Care Coordinators assessment of the Service Users Mental Health State?

- where existing audits rely on the collection of data from the clinical record key aspects of the CNST requirements are incorporated. Examples of such requirements are that all entries are legible, and that all entries are dated with printed name/legible signature of author.

Supervision:
The revised approach to Supervision within SCT needs to ensure that it enables;

- staff to receive a copy of the supervision record
- staff to be aware of those persons who can provide specialist supervision, and on what basis (this could be through a 'specialist' peer review system)
- the assessment of the effectiveness of an individuals case management and the quality of documentation
- a balance between the responsibility of the individual to seek out supervision and the responsibility of the organisation to ensure that it is provided on an 'at least as' basis, ie that the maximum time period between supervisory sessions is stipulated.

In addition to the above, SCT is encouraged to broaden its current audit tool for Supervision to allow staff to contribute ideas for improving the system of supervision and to describe elements that do not meet their needs as professionals. The clinical audit department might also consider increasing its sample size in Adult Mental Health and differentiating between in-patient and community services.

Medicines Management:
The Investigation Team is mindful that establishing, and evidencing, medication compliance in the community is fraught with difficulty. However, the Investigation Team does feel that the Directorate for Acute, Community and Primary Care Mental Health Services needs to open a dialogue with its local Primary Care Trust(s) and Local GPs to try and establish a workable system to enable Mental Health Workers to be made aware at an early stage if a Service User is not collecting their medications.

Interface with the Police Force:
The Investigation Team is aware that considerable effort has been invested by the Trust and in particular the former Service Manager for In-patient Services (Adults of Working Age) to establish a Sheffield Care Trust and South Yorkshire Police Joint Operational Procedures and Guidelines. Once this protocol/ information sharing agreement has 'bedded in' the Investigation Team encourages further development of this good work to establish a more effective communication system between the police and the Mental Health Service when a known Service User is taken into custody and released on bail. In the case of

S2 had such a system been in place the Care Coordinator would have been made aware of S2's assault on an apparently random passer-by on the 27th January. This would have increased the chances of a face to face assessment of S2 and the potential for an MHA assessment prior to the incident on the 2nd February 2004.

In addition to this work there may be some merit at the next liaison meeting between the Police Force and the Mental Health Service in establishing precisely what guidance is provided to the Forensic Examiners (Police Surgeons) regarding the appropriate route(s) of contact with the Mental Health Service if information regarding the Mental Health history of an individual is required.

APPENDICES

Appendix 1

Sources of Information Accessed

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

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

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

Table 1: Face to Face Interviews

Designation	Interviewed By	Date Interviewed (all in 2006)
Tenancy Support Worker working with S2	Maria Dineen and Dave Sharp	8 February
Assessment Officer, Vulnerable Persons and the Housing Officer Anti-social Behaviour Unit working for Sheffield City Council		
Care Coordinator S2		9 February
Team Leader West Continuing Needs Service		
Approved Social Worker, Services for Adults of Working Age		10 February
Approved Social Workers, Services for Adults of Working Age		
Team Leader Transcultural Service		
A selection of Transcultural Team Members		
SCT's Clinical Risk Manager SCT's Management of Violence and Aggression Coordinator	Dr Maureen Devlin and Dave Sharp	13 February
SCT's Effectiveness and Knowledge Manager Project Manager, Somalian Mental Health Project Manager Black Drugs Project SCT's Mental Health Act Administrator	Maria Dineen and Dave Sharp	20 February

Designation	Interviewed By	Date Interviewed (all in 2006)
Team Leader Sheffield Outreach Team	Jess Lievesley Maria Dineen	21 February
Ward Manager, Services for Adults of Working Age	Dr Maureen Devlin Jess Lievesley Maria Dineen	
Named Nurse for S2	Jess Lievesley Maria Dineen	
Area Manager SCT, CNS City	Maria Dineen and Dave Sharp	22 February
Care Coordinator S1		
SCT's current CPA Manager SCT's CPA Manager (2002 and 2003)		
Consultant Psychiatrist to S1 and S2	Dr Mark Potter Maria Dineen	1 March
Consultant Psychiatrist, Services for Adults of Working Age		
Care Coordinator, S2	Maria Dineen	
SCT's Medical Director and the Clinical Lead Services for Adults of Working Age	Dr Mark Potter Maria Dineen	6 March

In addition to the face to face interviews the Investigation Team lead held a number of additional telephone interviews with staff to cross check information provided at the face to face interviews.

Paper Records:
The following documents were reviewed and/or referred to during the course of the investigation:
Clinical Records:

- All SCT medical and community mental health records relating to S1 (seven volumes in total).
- All SCT medical and community mental health records relating to S2.

Policies and Procedures:

- Community Mental Health Sheffield and Sheffield Social Services Adult Mental Health Service Care Programme Approach Polices and Procedures 2002.
- Clinical Supervision Policy 22 December 1999.
- Operational Policy Continuing Needs Service, Sheffield Adult Mental Health Service March 2002.
- Sheffield Care Trust Operational Policy, Transcultural Social Work Team, Sheffield Adult Mental Health Services (2004, revised April 2005).
- Guidelines for special observations of patients at risk, November 1994 (ref: NPP.C15)
- Missing Patients, reference Riskpoli- 04 1999/2000

Other Documents:

- Serious Incident Review Group (19th May 2005) Review of Recommendations Following Internal Inquiries.
- Various records relating to training workshops provided to SCT staff in 2003 – 2004.
- Supervision Audit results March 2005.
- Medical Documentation Re-audit May 2004.
- Witness statement of the Forensic Medical Examiner for South Yorkshire Police who assessed S2 on the 26th January 2004.
- Mental Health Review Tribunal Report dated 29th November 2005 (S2).
- A variety of information booklets provided by the Somalian Mental Health Project .

Appendix 2

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 NPSA's 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 Maureen Devlin

Maureen is a pharmacist by training and after spending her early career running her own community pharmacy, joined the pharmaceutical industry on gaining her PhD.

During her time in the industry she undertook a variety of roles, culminating in the management of a team responsible for public policy analysis, political lobbying and media relations. During this time, Maureen was also granted honorary fellowship status at the Universities of Manchester and Birmingham, providing training on project management, time management and public-private partnerships, and undertaking research on performance management and priority setting.

She became an independent healthcare consultant in 2003 and has been working as an associate of Consequence UK since this time.

Jess Lievesley
Jess qualified as a Registered Mental Health Nurse in Cambridge in 1996, where he subsequently worked in their psychiatric intensive care and forensic services for 5 years. During this time Jess became interested in the care and support of individuals with the most severely challenging behaviour and was fortunate to be part of a team that enjoyed a number of very significant successes for the individuals in their care.

Jess left Cambridge in 2000, choosing alter this career aspirations to a community mental health setting, indeed having been recruited as a community mental health nurse within a newly commissioned Assertive Outreach service Jess went on to acquire a 1st Class (Hons) BSc as a Specialist Practitioner in community mental health care, which allowed him to train in and practice cognitive behavioural therapy, choosing to target those individuals with treatment resistant psychotic symptoms.

In 2002 Jess went on to manage both health and social care staff in a Assertive Outreach team within a more suburban area, from here Jess was responsible for implementing the requirements of the service as governed by the Department of Health Policy Implementation Guide, and was fortunate to be one of the earlier teams to be offering a 7 day service for their target client group.

Within this role Jess carried out extensive Audit into the efficacy and outcomes of the service and was asked to speak nationally on some of the outcomes that had been achieved.

In addition to managing the Assertive Outreach Service, Jess also spent time managing a community drug and alcohol service and carried out numerous internal investigations including those following a homicide.

In 2005 Jess was seconded to the Joint Commissioning Team and is currently the Mental Health Planning and Commissioning Manager for a population of 1.1 Million people, serving 8 PCTs and 1 County Council. Within this role Jess has been responsible for taking forward a number of key developments in relation to mental health service provision and has developed a specific interest in the Mental Health needs of Black & Minority Ethnic Populations.

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 User's care and directing the Team's overall resources accordingly.

Managerial Experience

1. **Lead Clinician, Wandsworth Adult Service, May 1993 – 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 – 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 “Consequence”, 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 People’s 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 “Independent Person” in respect of responding to the complaints process within a northern local authority.

Appendix 3

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 Mental Health Act 1983 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:
"Community 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."

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.

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 patient's/Service User's care and treatment. A range of tools and techniques are available to help with this including the NPSA's contributory factors framework, which was the tool used in this review.

Section 17 Leave: Section 17 leave is a prescribed intervention under the 1983 MHA, 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 patient's 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 'new' 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 patient's/Service User's care pathway, including significant events in a patient's/Service User's 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.