Root Cause Analysis Into the care and treatment of Patient X

West Yorkshire Strategic Health Authority

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Introduction

Mr A (the victim) died during the weekend of 26/27th May 2001, Mr X was arrested on 27th May 2001 and charged with his murder on 28th May 2001. Mr X subsequently pleaded guilt to the event and was sentenced to five years in prison. Mr X had been in contact with mental health services prior to the manslaughter. However, in the view of the independent Panel, the event "could not have been predicted and the mental health services could not have significantly effected the outcome of the incident". Mr X was not appropriate for secondary care mental health treatment and was not suffering from a mental disorder within the terms of the 1983 Mental Health Act.

Time Line

From November 1999 until the final incident, the Police were consistently called to the address where Mr X and Ms Z, his partner, lived due to domestic disturbances.

In March 2000 Mr X had taken a compulsive overdose which he immediately regretted and although assessed by the mental health services at the A & E department but failed to engage and attend any follow up appointments leading him to be discharged back to the care of his GP.

Mr X was then re-referred in August of 2000 with symptoms of depression by the GP for an assessment by the mental health services. During which time Mr X identified excessive alcohol consumption but did not regard this as a problem. Following team discussions by the Community Mental Health Team Mr X was offered anger management. Mr X subsequently was referred back to his GP after not attending the anger management sessions.

In March of 2001 Mr X was again referred to the mental health services for depression, anger and destructive behaviour, he was seen in the April and some advice about medication changes were sent to the GP with a plan to carry out a further assessment. On the 22nd May Mr X failed to attend for an appointment with a CPN and on the 26th May he carried out the attack on Mr A.

Summary of Care

Mr X was seen by a number of different health professionals but did not appear to successfully engage with any of them. The reluctance of Mr X to recognise his alcohol problem and a team culture that only worked with issues identified by the service user meant that the treatment plans often lacked focus and could be muddled.

There was a failure to follow the risk management processes and also the local Care Programme Approach, which may have lead to a clearer approach. The lack of a clear coordinator meant that Mr X was able to drift into and out of the service.

Given it also appears that Mr X did not meet the threshold for secondary care interventions this only added to some of the confusion about instigating an appropriate treatment regime.

An appropriate response would have been to refer Mr X on to the local community alcohol service, however this was never done.

Key Learning

The involvement of secondary care mental health services in this case only clouded the true underlying social issues in this case. Mr X did not have any symptomology that would require secondary care mental health input; indeed the primary issue appears to be one of alcohol abuse.

The incident appears to have occurred because Mr X was unable to control his alcohol consumption and this acted as a trigger for the loss of control of his temper.

The lack of any clear case coordinator and the fact that no multi-agency case conference or meeting was held around the case meant that information was not fully known by all parties and contributed to muddled interventions.

Recommendations

The report has produced a number of recommendations which include;

Provide a briefing for the GP about primary care issues from this incident.

Review how NICE guidelines for depression have been implemented in primary care.

Develop GP training relating to referrals into secondary care, agreeing joint access criteria.

Review the CMHT operational policy

CPN liaison with primary care GP attachment model implementation.

Staff work-groups to agree standard letters for outcomes of assessment to referrers that outlines problem area, assessment outcome and agreed treatment and care pathway(s). Letter to include any area of disagreement between assessor and client.

Development of educational packs for patients that are to be sent out with the outcome letters. (Educational packs to be sent where clients are in disagreement with assessment outcome).

Operational policy for Community Drug & Alcohol Teams needs reviewing and updating as the policy given to Panel was dated October 1994.

Review of record keeping policy.

There should be the development of electronic records accessible 24 hours, in line with the National Programme for Information Technology being run by the NHS.

Review and update the information sharing policy with the Police and other agencies.

Consider how the Emergency Duty Team keep records with reference to their personal notes.

Staff briefings and written information about how the information sharing protocol works and how they can be accessed and process required to access.

The developments in services since the incident

At the conclusion of this process, the Panel Chair and Tribal's Director of Mental Health held a most constructive meeting with the current Trust Chief Executive and his senior managers to

discuss this report in draft. It is clear that learning has already taken place, and that issues identified by the Panel now form part of the Trust's modernisation programme.

The Trust's action plan in response to our report will be presented separately to the Authority for its consideration.

1 Introduction

1.1.1 Tribal Consulting was commissioned under Health Service Circular HSG(94)27 by West Yorkshire Strategic Health Authority in July 2005 to provide an independent Panel which would review the care and treatment of Mr X who caused the death of Mr A in 2001.

1.1.2 Previously another independent review had been commissioned however this was not completed by the organisation charged with the task.

1.1.3 It should be noted that the significant passage of time since this serious and untoward incident occurred has influenced the review Panel's ability to retrieve documents effectively, successfully interview witnesses able to recall events.

1.1.4 The Panel would like to express their thanks to the staff that assisted this review. It should be noted that for some people this was the second time that they were called for interview. In particular thanks to those who helped provide essential information relating to assessment and outcomes but also very helpful information regarding the set up of services and processes, at the time and currently.

1.1.5 Mr X was charged with murder of Mr A and pleaded guilty to manslaughter in 2001 by reason of diminished responsibility; he was sentenced to 5 years. Mr X was a user of Mental Health Services following a referral from his GP.

1.1.6 The format of the review was to follow a structure of a root cause analysis to ensure that all appropriate lessons have been learnt and to minimise the possibility of such an event occurring again.

2 Process

2.1 Terms of Reference

2.1.1 To investigate:

- The care the patient was receiving at the time of the incident
- The suitability of that care in view of the patient's history and assessed health and social care needs
- The extent to which that care corresponded with statutory obligations, relevant guidance from Department of Health and local operational policies
- The exercise of professional judgement and the clinical decision making process
- The adequacy of the care plan and its monitoring by the key worker

2.1.2 To identify:

- The root causes of the incident and key learning points
- The developments in services since the incident

2.1.3 To make:

- A judgement as to the extent to which the current systems and processes in place would address the root causes of the incident and key learning points
- Realistic recommendations to address the root causes and to improve service

2.2 Membership of the Independent Panel

2.2.1 Chair: Ted Unsworth:

2.2.2 Ted is a director with Tribal Consulting, having extensive experience in the commissioning and operational management of health, social care, housing and criminal justice services for a range of vulnerable people. A former Director of Social Services and national mental health charity Chief Executive. Ted has particular expertise in mental health services, directing a number of major performance improvement consultancy assignments for the company. He is also a Panel member and accredited appraiser for the Mental Health Review Tribunal and has chaired a number of independent inquiries.

2.2.3 Nurse Manager: Karen Howard:

2.2.4 Karen has 26 years experience working in NHS provision of mental health and learning disability services in community and inpatient settings both in clinical and operational managerial posts. Karen holds both RNM and RMNH qualifications with additional experience and qualifications in forensic mental health care. Clinical and managerial forensic experience was gained in community, medium and high security settings. The forensic experience covers both mental health and learning disability services. Karen has undertaken consultancy work in other areas, both private and NHS providers which has included; setting up small group homes, reviewing NHS learning disability services and planning the re-provision with independent providers, helping to design a low secure unit for people with both learning disability and mental health problems and

providing the operational guidelines. Karen is experienced in reviewing serious untoward incidents using the root cause analysis process, examples of which have been suicides, unexpected death, negligence, and serious patient complaints. Karen has undertaken the National Patient Safety Agency (NPSA) root cause analysis training and most recently undertook the internal investigation/review of a homicide for Plymouth teaching Primary Care Trust. Karen was also an interviewee in the external Homicide inquiry so has direct experience of the process involved.

2.2.5 Consultant Psychiatrist: Dr Nathalie Robins

2.2.6 Nathalie trained in Manchester and qualified as a consultant psychiatrist, gaining her CCST in January 2001. Nathalie is bilingual, being half French, and went to France to work as consultant psychiatrist for 18 months before returning to Manchester, UK. Nathalie has worked at Trafford General Hospital, Manchester for last 2 1/2 years in general Adult psychiatry and has a special interest in forensic psychiatry and psychotherapy. She is also an honorary research fellow at University of Manchester and has been involved in examining trainee psychiatrists during their mock exams. She has been investigator and principal investigator for some clinical trials and presented findings and case studies at talks in the Northwest. Nathalie has previously been involved in a Homicide inquiry, where root cause analysis was used, as an interviewee so has direct experience of the process involved.

2.3 Methodology

2.3.1 The Panel used the Root Cause Analysis approach (RCA), using tools and techniques from the National Patient Safety Agency. Specific tools used are as follows:

- Tabular Time Line to establish the sequence of events
- Change Analysis RCA Tool
- Contributory Factor Classification Framework
- Fishbone RCA Tool

2.3.2 A number of staff were interviewed by the Panel whose names are appended to this report. With their consent these interviews were recorded, a transcript of the interview being subsequently provided to the witness for verification.

2.3.3 The Panel also had access to a number of other sources of information:

- Mr X's Mental Health medical notes
- Mr X's GP notes
- Mr X's Social Services records
- West Yorkshire Police records
- Policies in use in service at time of incident
- Internal report of the serious untoward incident written by the Acting Service Manager
- Panels view of HONOS Scores and risk assessment outcome at each mental health service contact

2.4 The Investigation

2.4.1 The timeline was prepared using the notes from the CMHT, GP, Medical notes, social services and forensic report. The sequence of events in the timeline posed questions and areas for further clarification. This in turn influenced the questions asked of the staff. Staff provided further information which clarified unanswered issues in the timeline as well as additional information with regard to their contact with Mr X and the victim, the services at the time, processes within the service and to some extent services currently. Some of the Panel observations about areas of improvements are drawn directly from contributions made by witnesses.

2.4.2 The Panel did not have the opportunity to interview Mr X himself as shortly before the independent Panel was commissioned Mr X went aboard and there was no forwarding address to contact Mr X.

2.4.3 The victim's daughter was contacted by the independent Panel via a mediation service and offered the opportunity to meet the Panel and give her views. At the time of writing this report this opportunity has not been taken up.

2.4.4 Contact could not be made with Mr X's family as no contact details were available.

3 Time Line

3.1 Background to Incident

3.1.1 Mr A (the victim) died during the weekend of 26/27th May 2001, Mr X was arrested on 27th May 2001 and charged with his murder on 28th May 2001.

3.1.2 Mr X stated to the Forensic Consultant Psychiatrist (during his time on remand at HMP Leeds) that his partner Ms Z also had a drink problem and he had been trying to assist her with reducing her intake of vodka. This was at the root of many arguments between them.

3.1.3 Mr X stated that there were additional problems as he believed that Ms Z's son had been using his credit card without his authorisation. Mr X believed he was paying off debts raised by someone else.

3.1.4 Mr X and Ms Z met the victim, Mr A, at the local public house, they both spoke to him as he seemed 'down'. They later became friends with Mr A because they felt sorry for him. Mr A went on to become a regular visitor to the home Mr X shared with Ms Z. In Mr X's words "he was always there". Mr X stated that Mr A supplied Ms Z with alcohol causing her intake to increase again and that he would regularly return home from work to find Ms Z intoxicated. Ms Z could not afford to purchase the alcohol herself and when she was intoxicated she was verbally abusive towards Mr X. Mr X stated that he would leave her and go to the bedroom, blocking the door with furniture. Mr X stated to Forensic Consultant Psychiatrist that he would often lose his temper at these times and that he had probably broken 80% of the crockery.

3.1.5 According to Mr X the Police were often called to disturbances at the home address, and on one occasion he called an ambulance for himself because he felt so angry, he was not allowed to leave hospital until he had calmed down. Mr X reported that the anger management that he received was not useful.

3.1.6 Mr X stated that over time he saw Mr A as trying to take Ms Z away from him. On one occasion he had found them together at Mr A's home and Mr A was partially undressed, although Ms Z was fully clothed. Mr X states he warned Mr A not to get Ms Z intoxicated, he did not recall having threatened Mr A, although work mates had suggested he beat him up. He did not want to do this as he knew Mr A's health was poor.

3.1.7 Approximately two weeks before the death Mr X rented a room across the road from the house he shared with Ms Z. This was to use as a bolt-hole for him if he needed to get away although he may not have ever slept there. On the day of the incident Mr X returned from a night shift, he had a bottle of whisky, which he drank moving onto cider. Ms Z also drank that day. There was a friend visiting on that day a Mr Y who was a good friend of Mr X.

3.1.8 Although Mr X himself did not remember this he was told later that he had an argument with Ms Z and left the house. His recollection of the rest of the day was poor, he thought he had consumed more alcohol and recalled visiting the local public house in the evening, where he believed he was refused service, at some point he returned home.

3.1.9 When he arrived home he found Mr A lying on the couch. Mr X has a vague recollection of grabbing Mr A's shirt and shouting at him, and that Mr Y (Mr X's friend) arrived at the house at some point during the altercation and tried to pull him away. Mr X states he threw a punch at Mr A. Mr X states he remembers Mr A lying on the floor looking up and smiling at him. He states he has no further recollection of the offence, all other information he has gained from witness statements in the depositions.

3.1.10 Prior to his death, Mr A informed the Bridge House CMHT on the 22nd May 2001 that Ms Z was now in a relationship with him and that Ms Z had taken out an injunction against Mr X. The internal report in May 2001 refers to the relationship of Ms Z and Mr A as factual, however this assertion is not supported by all the information gathered. Information gained at the Police station by the ASW attending on behalf of Ms Z refer to Ms Z as Mr X's partner. Nor does this information fit the information given by Mr X to the assessing Forensic Consultant Psychiatrist when he described returning to the home he shared with his partner Ms Z on the weekend of 26/27th May 2001. Ms Z also visited Mr X whist he was on remand.

3.1.11 Mr X was charged with the murder of Mr A. Mr X pleaded guilty to manslaughter in 2001 by reason of diminished responsibility and he was sentenced to 5 years imprisonment. The sentence release date was 26th May 2006, however Mr X was released early on conditional licence on 25th November 2003 after serving 23 months in prison plus 6.5 months on remand. Licence conditions were to attend appointments with his probation officer and also see a social worker.

3.2 Background and History of Mr X

3.2.1 Family History information was gained from Bridge House CMHT notes and Forensic report by Forensic Consultant Psychiatrist, all information was self reported by Mr X during assessments of him.

3.3 Personal History

3.3.1 Mr X was born abroad, he obtained normal milestones in his development, he described his childhood as normal, and that he got on well with his parents.

3.3.2 He states that he did not enjoy school as a small child and ran away from kindergarten. He settled once he started to attend primary school. He enjoyed his secondary education and was able to apply himself to the work.

3.3.3 After leaving school he attended a photography course, and he worked in a paper factory for 10 months. He then worked in the film processing industry for several years until he moved to England in 1995.

3.3.4 Mr X met his wife in 1980 they were married two years later in 1982 and separated in 1998. Mr X worked as a machine operator for 6 years in England. At the time of the incident he was divorced. Mr X stated that his marriage ended because of his excessive alcohol consumption. His move to England was an attempt to improve his marriage, as his wife was English.

3.3.5 Mr X has three children from his marriage, two daughters and a son. Initially he had regular contact with his children, which later reduced in frequency as his wife relocated to a different area.

3.3.6 At the time of the incident Mr X was in a two-year relationship with Ms Z, Mr X was living with Ms Z and was in full time employment.

3.4 Relevant Medical History

3.4.1 Mr X suffered with epilepsy from the age of 14 years, this was managed with medication. He stated that the number of fits had increased in recent years and he put this down to his increased alcohol consumption.

3.5 Past Psychiatric History

1998

3.5.1 Due to unhappy issues surrounding the end of his marriage Mr X saw a counsellor at Somerset House.

2000/2001

3.5.2 Mr X consulted his GP regarding depressive symptoms. He was prescribed an antidepressant (Fluoxetine) initially; this was later changed due to mood swings. Mr X took an overdose of medication in March 2000, following which he was referred to Bridge House CMHT for assessment. When he was seen by the CMHT the initial circumstances which had led to the impulsive overdose, which he states he immediately regretted, were believed to have passed. He continued to consult with his GP about depressive symptoms and concerns about lack of control over his temper. Mr X was referred again by the GP to Consultant Psychiatrist for further assessment and follow up. Following his assessment he was offered anger management. Mr X did not fully engage in this process and only attended an initial session with a trainee counsellor. Shortly before the incident, Mr X was referred again to the psychiatric services due to problems with his anger, relationship difficulties and symptoms of depression.

3.6 Pre Morbid Personality

3.6.1 Mr X stated he was able to get on with others, he did not smoke and he had used cannabis and LSD on two occasions. He also stated he had tried cocaine on one occasion after the end of his marriage. Mr X stated that he had drunk to excess at the weekend for several years, but was vague as to when this began.

3.6.2 In his interview with Forensic Consultant Psychiatrist Mr X estimated that he drank approximately 25 pints of beer between Friday and Sunday evening. However in his interview with the CMHT staff he gave a different amount of 15 pints between Friday and Sunday evening. Mr X described a few lapses of memory, which he related to his alcohol consumption. Mr X described problems with controlling his temper. He said after his heart attack he was told to release his anger more. Mr X stated his loss of control was more with his partner than with people he did not know very well. Mr X stated that his outbursts of anger were often, but not always, at times when he had been drinking. Mr X described his behaviour during these outbursts as breaking doors and windows.

3.7 Forensic History of Mr X

3.7.1 Mr X had a number of convictions during 2000 and 2001 including motoring offences, being bound over to keep the peace and possession of cannabis. Prior to the conviction for manslaughter, following a guilty plea, for which he received a sentence of 5 years imprisonment.

3.8 Forensic Psychiatric Opinion

3.8.1 Mr X accepted that he had a drink problem and had difficulties in anger control. The assessing Psychiatrist's view was Mr X was fit to plead, that he was not suffering from a mental or psychopathic disorder within the meaning of the Mental Health Act 1983.

3.8.2 Mr X had a binge pattern of alcohol consumption to the degree of having an alcohol dependency. At the time of the offence Mr X was intoxicated with alcohol. Mr X's history of depression was related to life events, he was in receipt of anti-depressant medication from his GP. However the depression was assessed in April 2001 and was not found to be so serious as to be a mental disorder within the meaning of the Mental Health Act 1983.

3.8.3 There was no evidence of psychosis upon assessment whilst on remand in prison, and the depression was also assessed to be mild.

3.8.4 The outcome of the assessment was that Mr X had a history of problems with anger control; this was exacerbated by alcohol consumption and relationship difficulties. The assessing Psychiatrist found no evidence to suggest that Mr X suffered from an abnormality of the mind so severe as to impair his mental responsibility as under the Homicide Act 1957, and therefore could not support an argument for diminished responsibility for the offence.

3.9 Sequence of Events

3.9.1 From November 1999 through to March 2000 the Police were called to the premises for Mr X and Ms Z for a number of domestic incidents.

3.9.2 Mr X took an overdose of dothiepin and excess alcohol in March 2000 and was seen in A&E. He was then referred to the Consultant Psychiatrist at Airedale General Hospital.

3.9.3 Mr X was referred to mental health service in March 2000 via A&E following the overdose for further assessment.

3.9.4 Mr X failed to attend a number of appointments sent but was eventually seen by a social worker in April 2000 and discharged back to GP as issues leading to overdose had reduced.

3.9.5 August saw a further domestic incident to which the Police were called.

3.9.6 In August 2000 GP referral to Bridge House. GP describes depression as severe with elements of agitation the referral is marked urgent.

3.9.7 In September 2000 Mr X was seen by CPN at Bridge House for assessment. Mr X estimates he consumed approximately 25 pints of beer between Friday and Sunday morning. Risk factors were identified as previous overdose and excess alcohol. But

there was strong denial by Mr X that alcohol was a problem or a factor in his aggressive outbursts, blaming others and circumstances for his problems.

3.9.8 07th September 2000 Mr X was discussed in multidisciplinary team meeting at Bridge House CMHT following the primary assessment and Mr X was placed on a waiting list for anger management.

3.9.9 The referrals from the GP were made with the same presenting problems, which were: relationship difficulties, alcohol dependent partner, mild to moderate depression (although GP referral states severe depression with some elements of agitation) and loss of control when angry (where he would smash up furniture and windows in the property). Mr X stated that his outbursts were often, but not always when he had been drinking. On each occasions Mr X was seen briefly and due to lack of attendance he was discharged back to GP.

3.9.10 September and October saw a continuation of the Police being called for a number of domestic incidents between Mr X and Ms Z.

3.9.11 On 15th November 2000 Mr X failed to attend appointment with student counsellor for anger management.

3.9.12 24th November 2000 Mr X was seen at Bridge House by counsellor, Mr X discussed his anger problem and how his partners drinking and financial problems affected his anger.

3.9.13 01st December 2000 Mr X failed to attend appointment for anger management, another appointment was sent.

3.9.14 15th December 2000 Mr X attended appointment with counsellor and he contracted to work on his anger problems.

3.9.15 December saw one incident of the Police being called to the premises to resolve a domestic dispute.

3.9.16 12th January 2001 Mr X failed to attend appointment for anger management, another appointment sent.

3.9.17 16th February 2001 Mr X failed to attend appointment.

3.9.18 01st March2001 Mr X was discharged back to GP by counsellor's supervisor due to non-attendance.

3.9.19 20th March 20/03/01 Mr X was re-referred by GP to Consultant Psychiatrist with concerns of depression, anger and destructive behaviour.

3.9.20 Following a further domestic dispute in April 2001 to which the Police were called, an ambulance was called and took Mr X to hospital; Mr X reported voices in his head. Ms Z stayed at property, Police informed the council with regard to boarding up the property.

3.9.21 25th April 2001 Mr X was seen and assessed by SHO and Consultant Psychiatrist, areas discussed in assessment were alcohol use, anger, destruction of property, relationship difficulties, Police involvement. The outcome was a referral to Bridge

Houses CMHT for further assessment, and some advice to GP regarding changes to medication.

3.9.22 During May 2001 prior to the incident, the Police were called on two other occasions to deal with issues of domestic violence.

3.9.23 22nd May2001 Mr X failed to attend appointment with CPN at Bridge House.

3.9.24 26th May2001 Returned home after drinking large quantities and found Mr A (victim) lying on couch, pulled at his shirt and punched him. Mr X remembers Mr A (victim) lying on floor smiling up at him, but does not recall any other details.

3.9.25 Police records detail: 'following previous domestic incident at his home address, Mr X punches the deceased and pulls him to the floor in the living room. He proceeds to kick the deceased numerous times around the head and body causing injuries, girlfriend and another witness present. The deceased manages to leave the house and returns to his home address where he later died as a result of the injuries sustained'.

Consequences

3.9.26 Death of Mr A the victim and Mr X charged with Murder. The forensic assessment, whilst on remand, could not support an argument for Diminished Responsibility in this case.

4 Summary

4.1 The care the patient was receiving at the time of the incident

The quality and scope of health care Mr X was receiving at the time of the incident

GP

4.1.1 Mr X at the time of the incident was under the care of the GP and was being treated with anti–depressant medication along with medication for epilepsy and a heart condition. The GP made a referral to the CMHT at Bridge House for Mr X describing the issues as *'quiet severely depressed with some elements of agitation, a lot of domestic crisis at home, possible relationship difficulties*'. He requests the team to '*keep an eye'* on Mr X and the referral is marked as urgent. There is no clear direction from the GP as to exactly what is being asked for in this referral, and notably the referral is made to the CMHT rather than through to the Consultant Psychiatrist.

4.1.2 On 20th March 2001, ten and a half weeks (53 working days) prior to the incident, Mr X had been referred back to the Consultant Psychiatrist at Airedale hospital by his GP. The referral was marked as non-urgent.

4.1.3 The GP was concerned that Mr X was still *'quite significantly depressed in spite of his medications and had a recent bout or smashing up most of the windows in the house and most of the furniture'.*

4.1.4 The GP was looking for advice as to how to proceed and further management. Thirteen working days after this referral Mr X had called an ambulance himself and been taken to A&E with what was described as an anger attack. Mr X reported to A&E staff that he was afraid of hurting his girlfriend and what damage he might do. This information was sent to the GP, but it appears that this was not communicated to the psychiatric services, that the Panel can identify.

4.1.5 Within the GP records there is an entry dated 2nd May 2001 stating *'seen by counsellor who suggested may be more appropriate for more sedating anti-depressants. Is still having violent outbursts*.' It was suggested that the GP try amytriptylene 75mgs nocte, however in GP computer records this is recorded as 25mgs.

4.1.6 It is unclear who prescribed amytriptylene as this is recorded as citalopram in the consultant psychiatrist's letter of 25th April 2001 to the GP. Certainly it would not be for a counsellor to make recommendations about medication. There is also a concern about the interaction with other medication and amitriptyline is not a good drug to use if there is a risk of overdosing.

4.1.7 When reflecting on the circumstances at the time the Panel has concluded that the re-referrals back to secondary mental health care on two occasions lacked purpose and clarity as to exactly what was being expected from the team. The GP appeared to have no clear direction as to the way forward with this mans treatment. Despite discharge back to the GP within a few weeks there is another referral. Upon reflection a "face to face" meeting of professionals would have been of more value and provided clarity of roles.

4.1.8 The level of depression appears to be the sort normally found in primary care. However there is conflicting information in the internal report and in the evidence from the consultant psychiatrist in her report to the chief executive some months after the incident. In the report to the CEO the depression is described as a mild to moderate such as you might find in general practice. The internal report records the diagnosis as depression, agitation and relationship problems. The mild to moderate depression is not noted in assessment outcome letter from the SHO back to the referring GP.

4.1.9 There was apparently no counselling service in the GP practice at that time, which may have been of more benefit to Mr X. There was no mention of alcohol problems, which appeared to be his main difficulty, although this is recorded in the GP notes December 1998 in the summary section. There is also one entry January 2001 where the GP seeing Mr X has recorded that he "*looked tired, smelt of alcohol – but denies any alcohol consumption".* In addition to this entry, letters to the GP from the mental health services April 2001 and September 2000 make reference to excess alcohol use and reference to the quantities self reported by Mr X.

4.1.10 A referral from primary care to the alcohol services may have been beneficial, although referral to this service requires patient motivation. In summary the quality of the care was reduced by the lack in clarity and direction of the real issues, the scope of the care was limited due to limited mental health awareness of the GP and the response of referring on to secondary services rather than exploration of the issues at primary care level.

Consultant Psychiatrist /SHO

4.1.11 The referral from the GP appears to assume that the psychiatric medical input is separate to that of the Bridge House CMHT. An assessment was made which determined that excess alcohol use, loss of control of temper due to alcohol, relationship difficulties and some mild depressive symptoms were the problem areas.

4.1.12 The SHO upon interview with the Panel has identified that he was new in post, enthusiastic and wanting to try to help everyone. He states that now he most likely would not have seen it appropriate to offer secondary services.

4.1.13 The consultant psychiatrist, who only saw Mr X for a short period of time as part of the supervision of the SHO, has stated in interview that she was keen to provide support to the GP practice. That at the time it was worth trying to offer help as there were no real other alternatives for Mr X. It was felt that there was a possibility that anger management would help it was worth trying. At the time the services were trying to 'do all for everyone'. This was in spite of the clear referral criteria for those in most need.

4.1.14 In summary the psychiatric medical input did not impact on the wellbeing of Mr X. Again the main issues of excess alcohol use, loss of control of temper and relationship difficulties were not really addressed or clearly communicated back to GP. These unaddressed issues were the main factors, in the Panel's opinion, of Mr X's inability to control his temper and ultimately were part of his relationship difficulties, and a consequence of his drinking was his low mood.

4.1.15 The Panel's impression was that of the issues not being discussed upfront with Mr X, but 'skirted' around without real purpose. The approach was humanist, in that the service tried to assist, positive impact would not be achieved unless Mr X admitted that he had an alcohol problem, so could be described as maintaining the status quo.

Community Mental Health Team (CMHT)

4.1.16 Mr X in all was offered three primary assessments, one after his overdose in March 2000, another following an urgent referral by the GP in August 2000 and a further referral in April 2001 from the SHO to the Consultant Psychiatrist. Each time he was offered a primary assessment and the assessment was carried out, excess alcohol, difficulty controlling anger and relationship difficulties were identified. Following the first primary assessment Mr X was discharged back to the GP as it was believed that the causes of the overdose had since diminished and Mr X was identifying that he could cope.

4.1.17 From his second primary assessment, the referral marked urgent from the GP, it was concluded that Mr X's compliance with medication was erratic, and he appeared unhappy with his situation as opposed to being clinically depressed. The team discussed his assessment and placed him on the waiting list for anger management, sent an anger management pack and asked to contact the team if he was unable to cope in the mean time. This action is in contrast to the urgent referral made by the GP. It seems a passive response, but fits the 'nurturing all inclusive, looking to try and help everyone, give them all a chance' approach which the Consultant Psychiatrist described in the interview with the Panel.

4.1.18 From staff interviews it has been established that Mr X was asked about his alcohol use, a referral to alcohol services was discussed but Mr X was in firm denial that it was a problem. Unfortunately these important details/opinions were not documented.

4.1.19 Due to pressure of work, anger management was eventually offered in November 2000 by a trainee counsellor who was supervised by a mental health therapist. Mr X failed to attend his first scheduled appointment, he was sent a second one for which he attended, agreed and signed a contract for the work. During this session he discussed feeling 'stuck' about a decision whether to return abroad, claimed he dealt with anger by walking away, but noted that he may not always be able to do this.

4.1.20 From staff interviews it has been identified that the trainee counsellor would not have been assigned to Mr X if it was felt that his primary need was excess alcohol use. However from the staff interviews and documentation the Panel conclude that indeed this was the primary need. The trainee counsellor did have a discussion with Mr X about how he dealt with anger, which was to walk away. Mr X added that this may not last forever, although this was recorded it was not discussed by the team and the supervisor cannot recall this issue.

4.1.21 Mr X failed to attend his next appointment. He did attend a further appointment; however no details of session were recorded except the signed contract with Mr X giving his permission for the sessions to be taped. Following failure to attend two further appointments Mr X was discharged back to the GP. Looking at these events the Panel concluded that what was required was for a face to face discussion with the GP to establish what each profession was aware of, what the GP concerns were and an agreed plan of action.

4.1.22 A further referral to the Consultant Psychiatrist was made by the GP to the service in March 2001 following a heavy bout of drinking when Mr X broke most of the windows and furniture in the house. Mr X was seen by the SHO in April 2001; it was recorded that the loss of control of temper was increasing, usually associated with excessive alcohol intake. This assessment concluded that the issues were excessive alcohol

consumption, poor anger management related to a volatile relationship, and made suggestions to changes in medication. The SHO then referred Mr X back to the CMHT for further assessment. Mr X had an appointment for 16th May 2001, but he failed to attend.

4.1.23 The CPN received information from Mr A, the victim, informing the service that he was in a relationship now with Ms Z who had taken an injunction out against Mr X. It was concluded by the CMHT that this meant it was possible Mr X was not living at the address the letter was sent to. The plan was to discharge back to the care of the GP asking the GP to get back in touch with the service if their involvement was indicated. However the internal report suggests that the service was awaiting a re-referral from the GP with a current address. There was some conflicting information with regard to the outcome of the last referral and no clarity has been gained about which event is accurate.

4.1.24 In summary the Panel have concluded from the information available that the quality and scope of the care was limited and superficial. The care lacked clarity, depth, was poorly documented, with sparse information. There was no care plan and specific discussions at team meetings including rationale for decisions has been lost due to lack of processes to formally capture and document this information.

4.1.25 All members of the team conclude that Mr X's primary need was excess alcohol yet this appears to have remained unaddressed, and was not specifically communicated to the GP. It is referred to in the letter back to the referring GP along side noting a referral to the CMHT for further assessment. This may have indicated to the GP that the team could offer more care.

4.1.26 The symptoms of the excess alcohol consumption i.e. volatile relationship and poor anger control became the focus of the issue. Patient care demonstrates that without the real issue of excess alcohol use being addressed the other issues would most likely not respond positively.

The quality and scope of Social Care Mr X was receiving at the time of the incident

4.1.27 Mr X did not have any input from social services until his arrest. There were no circumstances requiring their services. Mr X had access to his children, although his contact with them was infrequent as his ex wife had relocated to another area. There were no child protection issues.

The quality and scope risk assessment Mr X was receiving at the time of the incident

4.1.28 The internal review recorded that there was '*increasingly frequent history of violence towards property often related to alcohol consumption. Incidents of physical violence towards people not evident'.*

Bridge House CMHT

4.1.29 The CMHT did not make a formal record of any risk assessment on the 'FACE' (Function Assessment in Care Environments). This is the risk assessment tool included in the CPA paper format. It is described in the CPA policy and practice guidelines 2001/2003 "*as a comprehensive risk assessment and risk management tool*

that is designed to be used by mental health services". This tool is described in the CPA policy as:

- Providing a convenient way of summarising and collating key information that is also easily accessible
- A structured method of reminding professionals of areas that should be covered when screening for risk
- A means of recording that basic screening for risk has been carried out
- A means of recording risk management plans
- A format that is understood by all agencies in mental health service provision.

4.1.30 There was no formal documentation of risk in any of the contact held with Mr X. In the primary assessment made on 24th April 2000 the risk factors documented are reoccurrence of stress:

- Contact arrangements with the children, the ex wife making it difficult for Mr X to see his children
- Tensions with partner's son.

4.1.31 In the second primary assessment of Mr X made by the senior CPN at Bridge house on 4th September 2000 the risk factors were recorded as:

- Previous overdose of Dothepine and alcohol March 2000
- 'Bad thoughts' about suicide but no plans and parents and children gave him a reason to live
- Drinks 15 pints over sat & sun. Denies alcohol is a factor in his outbursts of aggression
- ? Potential for harm to others.

4.1.32 This last point 'potential for harm to others' is not expanded upon further. Although alcohol use and denial of problem is recorded, the depth of this discussion and the suggestions of referral to alcohol services described during the interview with the Panel are not documented in the assessment.

4.1.33 The third referral to the CMHT was from the SHO for further assessment. An appointment was sent out to Mr X for 22nd May 2001, which Mr X failed to attend, no further assessment took place.

4.1.34 Although minutes of the team meetings were kept, there is no record within these of the clinical discussions, it relied on those present to record in patient notes relevant information from the meeting. Unfortunately discussion with the team about Mr X were not recorded at all or not recorded in any real depth so information about decision making and rationale have been lost.

The SHO

4.1.35 The SHO to the Consultant Psychiatrist at Airedale hospital received a further referral from the GP marked as non-urgent. The SHO (and the Consultant Psychiatrist for a brief period of time to confirm the SHO assessment) saw Mr X on 25th April 2001. There was no formal risk assessment made at this assessment. The issues recorded are as follows:

- Problems associated with anger management and excessive alcohol intake
- Two year history of problems in controlling his temper which leads to smashing up furniture in his house and putting through windows, usually associated with excessive alcohol consumption
- Volatile relationship with partner and their alcohol consumption appears to lead to the episodes
- 20 episodes of violence lasting between 10 – 30 minutes and these were occurring at increased frequency but denies physical violence to partner
- Police called on approximately 10 occasions where he was arrested and taken to cells to cool down but released without charge.

Mental Health Therapist

4.1.36 Mr X was offered anger management with a trainee counselor supervised by the mental health therapist. Mr X was seen 24th November 2000, the issues documented are:

- His partner's drinking
- Financial difficulties
- Feeling stuck about whether to stay in Britain or go back to Canada.

4.1.37 It is recorded that Mr X described the above as having an effect on his anger. It is also documented that Mr X stated that at that time he walked away from the issue rather than staying and breaking things, but he '*felt that this may/cannot last forever'.* There is no more documentation about any further exploration of this last statement and it is unclear after the passage of time whether this was picked up upon. There was no formal documentation of risk by the mental health therapist, and this information was not given to the GP in the correspondence informing him of discharge from the team following nonattendance. The risks that Mr X alluded to in his interview regarding anger management were not picked up upon or discussed further, which was a lost opportunity.

4.1.38 The Panel has attempted to record what they felt the formal assessments should have noted. It is evident that the HONOS scores go up and down at each contact, the contact in March 2000 the score was 12, April 2000 the HONOS score was 9, and at the last contact in April 2001 the Panel scored this at 15. These show that the contacts from the service did not improve the problem areas.

4.1.39 In November 2000 and then April 2001 he calls an Ambulance as he is afraid of the damage he might do. On the latter episode there is no recorded indication from A&E that the issue is alcohol related. However information from the Police records he was drunk and Police records clearly shows the extent of the life style issues and excess alcohol consumption of both Mr X and his partner Ms Z. There were 13 call-outs of Police for domestic violence incidents and two court appearances, two for Mr X, which included a joint court attendance with Ms Z for breach of the peace.

4.1.40 There is information from Mr X in September 2000, when assessed, that he was not consistent, described as erratic, in compliance with taking prescribed medication for depression.

4.1.41 When Mr X was assessed by Forensic Consultant Psychiatrist whist on remand he acknowledged that he had drunk to excess for several years. He made mention of memory lapses related to alcohol consumption and relates to problems controlling his temper, but not always, at times that he had been drinking. This information does indicate that the risk is escalating but not due to mental health problems. However it should be noted the CPA policy does state that the FACE assessment is not a prediction of future risk, but to identify the level of risk for consideration of planning care.

4.1.42 In addition to the lack of formal risk assessment, given the frequency of contact with the Police around a number of domestic and disorder issues there was no liaison with the Police, despite evidence being discussed with the Panel that there were routes to gain access to Police information/involvement through the forensic CPN. It could have been expected that a discussion with the forensic CPN about the case would have occurred to review the issue of liaising with the Police. Liaison with the Police would have aided the services ability to see that these issues were not for secondary mental health care. That this was a personal responsibility involving excess alcohol, domestic violence and requiring the criminal justice route.

4.1.43 In summary the Panel concluded that the risk assessment was not adequate, no formal record of the agreed risk assessment tool was completed.

4.2 The suitability of care

Any previously identified psychiatric history including drug and alcohol abuse

4.2.1 Mr X had a significant alcohol problem, which had been present for a number of years. There is evidence to show that he had relationship difficulties due to use of alcohol prior to the relationship with Ms Z, in fact it is given as one of the reasons his marriage failed.

4.2.2 The Panel has concluded that involvement of secondary mental health care beyond the initial referral for assessment following the overdose was not suitable as it was not required.

4.2.3 What was required was some direct honesty from Mr X and from the mental health staff to Mr X with an emphasis on personal responsibility, and referral to address his excess alcohol consumption. From interviews with staff most say they believed his problems were mild depression due to excess alcohol use, yet none of the correspondence sent to the GP states this explicitly. The correspondence only refers to the excess alcohol consumption in one letter as one of the risk factors, and in the last letter to the GP from the SHO it is referred to at the beginning of the letter in an account of Mr Xs view of his problems.

4.2.4 The care provided by primary care did not pick up on the information sent from the services identifying lack of engagement, lack of significant depressive symptoms. In interview the GP believed that he was unaware of the issue of alcohol, although the Panel's view is that there was enough information available for this conclusion to be drawn.

4.2.5 The Panel have concluded that there were no indicators for any social care to be provided to Mr X.

Number and nature of any previous Court convictions – Forensic History

4.2.6 Liaison with the Police or the forensic CPN to ascertain previous convictions may have revealed information to give the treatment plan greater focus. There was significant information given by Mr X himself, which could have prompted the CMHT staff to make enquiries. Access to the records of West Yorkshire Police would have allowed the service to crystallize their thinking about the issues and refer back to primary care and clearly identify that Mr X did not required secondary services. The Police information would have indicated that the mental health service response to Mr X was to inform him to take some personal responsibility to address his excess alcohol consumption. However it is accepted that routine forensic screening of all referral is not always possible.

4.2.7 West Yorkshire Police records show a continuation of domestic violence and alcohol related aggression and property destruction from November 1999 through until May 2001 just before the homicide. In total there were 13 Police call outs to Mr X and Ms Z. All of these recorded incidents were alcohol related.

4.3 The extent to which that care corresponded with statutory obligations

Statutory obligations, national guidance (including HSG (90)23/LASSL (90) 11)

4.3.1 The care was superficial and did not identify the above guidance and follow its requirements.

4.3.2 The discharge information did not clearly identify the focus of the problem.

4.3.3 CPA policy was in place, but not used, there was no formal risk assessment using the agreed tool FACE.

4.3.4 HONOS assessments were not completed.

Existing operating systems available for use

4.3.5 Had there been sharing of information with Police and gaining information about Police involvement, domestic violence and forensic history the view from the service may have altered.

4.3.6 Face to face liaison with GP could have provided an agreed outcome of discussing frankly the alcohol issue with Mr X and given better direction to primary care.

4.3.7 Referral to alcohol services may have encouraged Mr X to attend and start to look at his drinking, or provide the team with expert advice on his case management.

4.3.8 The care did not follow the CMHT operational policy guidelines as to who would be offered a service. It states that priority will be given to:

- People who have recently been discharged from hospital
- People who are at risk of suicide/deliberate self harm
- People who have enduring mental heath problems
- Mothers with young children

4.3.9 Mr X's problem areas did not fall into any of these categories.

4.3.10 In summary the Panel concluded that there were no specific statutory obligations towards Mr X from the specialist secondary services. Also there is no specific relevant guidance from the Department of Health that would have assisted with the primary need, that of excess alcohol use and associated problems. Upon reflection of the circumstances at the time if the CMHT staff had focused on the criteria identified in the operational policy this would have opened up a more appropriate care pathway via primary care, individual responsibility and alcohol education.

4.4 The exercise of professional judgement

4.4.1 The Panel has concluded that the professional judgment and clinical decision making of those involved in the care was lacking in clarity. The involvement, although with Mr X's best interests at heart trying to be helpful and give him 'a go' as described in one of the interviews, was at best superficial. A more directive approach may have helped Mr X critically examine his life style problems.

4.4.2 The SHO describes himself in interview as new in post and that the Consultant Psychiatrist took any care management decisions. Now reflecting on the circumstances he feel that he would not have referred Mr X on for further assessment, he was of the view that excess alcohol was the main issue.

4.4.3 The medical assessments of Mr X did not conclude that he was clinically depressed. Nothing much had changed between the assessments except the bouts of loss of control of anger were escalating. These assessments noted excess alcohol, but did not address this.

4.4.4 The Panel concluded again that the involvement of secondary services had no real purpose or outcome, that the professional judgment and clinical decision making was superficial and lacking in purpose.

4.4.5 The CMHT staff on first referral made an assessment that identified it was not a secondary care issue and gave practical advice. The second assessment identified that little had changed, that excess alcohol consumption was present and that Mr X appeared unhappy as opposed to clinically depressed. He was placed on the waiting list for anger management. At the interview with the Panel, one view given was that of "*excess alcohol being the main problem but Mr X denied this, so what can you do?"* , this approach demonstrating the teams view that they could only work with individuals on the issues that the individual identifies.

4.4.6 The GP missed the frequent reference to problems being associated around excess alcohol use. In our opinion the GP seemed to want someone else involved in the care as a 'fall back position' in what seemed to be a safety net for the practice rather than expecting a specific purpose.

4.5 The adequacy of the care planning

4.5.1 There was no specific identified key worker (care co-ordinator) appointed. From staff interviews this was because Mr X did not engage fully in care so the CPA process was not commenced and at that time only enhanced CPA criteria was in use.

The extent to which this client's prescribed treatment and Care Plans were documented

4.5.2 There was no care plan written. Mr X attended an appointment where he was described in the clinical notes to have 'contracted' to undertake anger management and signed a consent form allowing the sessions to be taped. No CPA documentation was completed. Staff interviews indicated that this was due to the CPA policy not quite being in implementation stage and that at that time only those client's discharged from hospital had CPA format completed. However this is in contrast to the CPA forms the Panel were given which indicated they were in use in January 2000.

The extent to which this client's prescribed treatment and Care Plans were agreed with Mr X

4.5.3 There was no prescribed treatment or care plans agreed with Mr X. There is no documentation that a specific plan was discussed and agreed. The letters, documentation and staff interviews demonstrate that the assessments were made and then discussed in a team meeting. Mr X was then written to and informed of the outcome and offered an appointment for anger management. This approach would have been more appropriate for someone who required secondary care.

4.5.4 The Panel concluded it was not a style indicated where the individual needed to take personal responsibility for their behaviour it certainly was not an inclusive approach to Mr X.

The extent to which this client's prescribed treatment and Care Plans were communicated with and between relevant agencies and his family

4.5.5 The Panel has concluded that there was no specific care plan or direction of treatment outlined. The changes in medication were advised by letter to the GP, and there is evidence that further advice regarding medication was given. However it is not clear where this advice came from, and indeed the way the GP records reflect it raises a concern around a 'counsellor' giving advice about medication. It is not clear who this was and when and in what circumstances the advice was given. There was no involvement with other agencies or the family. It would have been appropriate to discuss the increasing anger with the Police to get a fuller picture of the circumstances, this the Panel believe would have clarified the situation.

The extent to which this client's prescribed treatment and Care Plans were delivered and complied with by Mr X

4.5.6 From Mr X's own information to the CPN on his second assessment his drug compliance was poor, and the offer of anger management was not followed through by Mr X. Mr X also failed to attend a number of appointments offered to him by the CMHT and was described as being in denial about excess alcohol being a problem. However when interviewed when on remand he stated that he had drunk excessively for several years and identified it was the cause of his marital break up. Mr X says he received some anger management, which were not helpful and in reality he only attended 2 sessions. The Panel concluded that Mr X was not motivated to address his excess alcohol use, or willing at the time to look at his life style choices, both of which were his primary problem. This was also evident by his lack of commitment to attend appointments.

4.6 Inter-agency Working

To Review the inter-agency working and communication between Health, Housing Authorities, Social Services, Police and any other agencies, which were, or might appropriately have been, involved in the care of Mr X

4.6.1 The agencies involved in his care were mainly health organisations the GP, Mental Health Services, A&E and Police. The Panel concluded that there should have been contact with the Police to establish what they were aware of and to get a fuller picture. This will include the domestic violence and previous convictions, which would have helped fully, assess Mr X for risk and plan of appropriate care and outcome.

4.6.2 The Panel has concluded there should have been better liaison with the GP, that the staff and GP should have met to discuss the issues face to face, or at the very least had a telephone discussion about Mr X. The GP did not inform CMHT of anger attack on 5th April 2001 despite his recent referral, this would have been helpful information.

4.6.3 The Panel concluded that the care and referrals were circular without direction or outcome, superficially skirting round the issue.

5 The root causes of the event and key learning points

5.1.1 The Panel has concluded that there were no specific root causes of the incident with regard to the mental health services. The death could not have been predicted and the mental health service involvement did not significantly impact upon the outcome. However had the outcomes of the assessment specifically directed the referrer and Mr X to personal responsibility and excess alcohol use, Mr X may have been more motivated to address his lifestyle and excess alcohol use which may have had some impact on the final outcome.

5.1.2 The secondary mental health service involvement had the effect of clouding the issue by not addressing the excess alcohol directly, but the onus was on Mr X to take responsibility for his behavior and life style and reduce his drinking. It appears these issues were raised with him, but he denied that there was a problem. A key learning point form the latter is to ensure that staff document these discussions and communicate them clearly to the referrer.

5.1.3 The Panel concluded that had more extensive liaison taken place with the Police the full extent of the domestic violence issues, alcohol and life style choices would have been evident and a clear indicator of the nature of the real problem. This would have provided clarity that this was not a secondary mental health care issue.

5.1.4 The Panel sees the following as key learning points: Mr X did not require secondary mental health services; and future assessments where alcohol is seen as a primary problem the response to the client should be clearly stated, and documented in detail, advice & education given and client response also documented. Follow up letters to primary care should also clearly outline the issue and personal responsibility of the client.

5.1.5 Mr X did not have symptoms of mental illness warranting a specialist secondary mental health service input.

5.1.6 Mr X's problem areas were primarily alcohol abuse and relationship difficulties.

5.1.7 The GP did not pick up upon the references in letters and notes from GP colleagues that there were concerns about excess alcohol use, and therefore primary care did not fulfil its educational role and make a referral to alcohol services direct.

5.2 Issues that were considered to be of greatest significance

- Mr X did not have symptoms of mental illness requiring a secondary care service
- Mr X's apparent failure to acknowledge the extent of his excess drinking was a trigger to loss of temper control
- Mr X life style choice and blaming his problems on others or circumstances
- Perpetrator, victim and perpetrator's partner all known to CMHT although the team did not seem to have given this dynamic sufficient attention in devising care plans which should have demonstrated a more comprehensive view of life styles as all clients were known for excess alcohol use
- Direct responsibility of patient and focus on primary issue not clearly defined or communicated to patient or GP

5.3 Influencing factors

- Service tried to offer help generally rather than focus on the requirement for Mr X to take some personal responsibility for his life style choices and address his primary problem, which was alcohol abuse
- Mr X's failure to engage with service properly
- Mr X's life style, alcohol abuse and denial of alcohol problem
- Mr X's amount of alcohol use, his denial that alcohol was a trigger to loss of temper control
- No formal documentation of the risk assessment, this may have focused the service on what the issues were
- More liaison with Police, may have assisted in the service being more focused about the key issue
- Lack of education advice on alcohol abuse. It appears to have been discussed but not documented
- Lack of clarity in communications with GP
- No formal risk assessment
- No interagency co-operation, i.e. liaison with Police
- Poor liaison with GP to establish how concerned GP was with situation
- Lack of clarity and poor quality of record keeping which leads to issues of superficial input by service
- GP's mental health expertise and lack of awareness of alcohol abuse
- Lack of referral to alcohol services from primary and secondary care, GP did not recognise the alcohol problem
- Superficial assessments of risk and issues, the issues needed more in depth exploration and assessment

5.4 The developments in services since the incident

5.4.1 At the conclusion of this process, the Panel Chair and Tribal's Director of Mental Health held a most constructive meeting with the current Trust Chief Executive and his senior managers to discuss this report in draft. It is clear that learning has already taken place, and that issues identified by the Panel now form part of the Trust's modernisation programme.

5.4.2 The Trust's action plan in response to our report will be presented separately to the Authority for its consideration.

6 Recommendations

6.1 Primary Care

6.1.1 Provide a briefing for the GP about primary care issues from this incident.

6.1.2 Review how NICE guidelines for depression have been implemented in primary care.

6.1.3 Develop GP training relating to referrals into secondary care, agreeing joint access criteria.

6.2 Secondary Care

6.2.1 Briefing for staff

6.2.2 Review the CMHT operational policy to include:

- Criteria of access
- Recording of referral meetings /clinical discussions
- Include standard letter format with reason for referral, purpose of initial assessment in the operational policy
- Criteria for taking onto CMHT case load to be established
- Eligibility for CPA needs definition in CMHT operational policy
- Agree standard outcomes of assessment, letters to go to referrers and copy to patient which outlines areas of problem, agreed treatment and care path/pathways
- Operational policy to include information about giving accurate information to patients about their personal responsibilities and life style choices
- Case load management and supervision records policy to be reviewed and to include keeping ongoing records of each discussion
- Process for allocation of referrals to care –coordinators to be described in policy.
- Development of a discharge policy within the CMHT operational policy – although it is referred to in the CPA policy – either as a specific addition or more clearly cross referenced between the CPA policy and CMHT operational policy

6.2.3 CPN liaison with primary care GP attachment model implementation.

6.2.4 Staff work-groups to agree standard letters for outcomes of assessment to referrers that outlines problem area, assessment outcome and agreed treatment and care pathway(s). Letter to include any area of disagreement between assessor and client.

6.2.5 Development of educational packs for patients that are to be sent out with the outcome letters. (Educational packs to be sent where clients are in disagreement with assessment outcome).

6.2.6 Operational policy for Community Drug & Alcohol Teams needs reviewing and updating as the policy given to Panel was dated October 1994.

6.2.7 Review of record keeping policy to include:

- Practitioners must record date of next appointment when documenting records
- List of agreed and recognised abbreviations to be included in policy
- Printed surname & designation as well as signature

6.2.8 There should be the development of electronic records accessible 24 hours, in line with the National Programme for Information Technology being run by the NHS.

6.3 Multi–Agency Issues

6.3.1 Review and update the information sharing policy with the Police and other agencies.

6.3.2 Consider how the Emergency Duty Team keeps records with reference to their personal notes.

6.3.3 Staff briefings and written information about how the information sharing protocol work and how they can be accessed and process required to access.

Appendix A - Interviewees

Mental Health Therapist in 2000/2001 Provided interview only

Consultant Psychiatrist in 2000/2001

CPN in 2001 currently Team Leader for Bridge House

CPN/Acting Team Leader 2000/2001

General Practitioner 2000/2001

ASW Emergency Duty Team Social Services 2001

Specialist Registrar in CMHT 2000/2001

Telephone Interviews

Team Leader Bridge House 2000/2001 Provided telephone interview

SHO to Dr McKenzie in 2000/2001 Provided telephone interview

Written Statements

Social Worker in CMHT 2000/2001 Provided written information only

Consultant Psychiatrist in 2000/2001

CPN in 2001 currently Team Leader for Bridge House

CPN/Acting Team Leader 2000/2001

General Practitioner 2000/2001

ASW Emergency Duty Team Social Services 2001

Specialist Registrar in CMHT 2000/2001

Bridge House CMHT Team Administrator 2000/2001

Appendix B – Documents Used

Copy of Airedale NHS Trust Bridge House CMHT file for Mr X

Original CMHT Records for Mr X

Bradford Social Service File for Mr X

Copy of Airedale NHS Trust Medical File for Mr X

Copy of General Practitioner file for Mr X

West Yorkshire Police Documentation

- 12 IBIS logs – call out and command Logs various dates
- Printout from the Crime Information System in relation to the murder of Mr A
- Previous convictions of Mr X
- Printouts from the domestic violence index – various dates

CPA Policy and Practice Guidelines for Health & Social Care Staff working in Airedale & Bradford.	2001 / 2003
Bradford Health & Social care Partnership Draft Interagency Protocol for Sharing Information	Nov 2003
Bradford NHS/Airedale NHS Trust/Bradford Community health/Bradford Metropolitan District Council CPA leaflet –	2000
Bingley /North Keighley CMHT - Draft Operational Policy	2000
Bingley /North Keighley CMHT - Operational Policy	2002
Airedale NHS Trust Procedure adverse Clinical Incident	2001
Airedale NHS Trust Documentation of Care Policy	1992
Airedale NHS Trust Guidance for Serious Untoward Incidents (SUI)	1998
Forensic Psychiatric Report	Oct. 2001
Example of CPA paperwork in use	2000
Example of CPA forms in use	2005
Airedale NHS Trust Mental Health Services - initial internal report	May 2001
Airedale NHS Trust - Final Draft Caseload Management Guidelines	Jan 2001
Bradford District Care Trust Caseload Management Guidelines	July 2003
Airedale NHS Trust Mental Health Services Clinical Supervision policy	Jan 1995

Bradford District Care Trust Clinical Supervision policy	Nov 2003
Clinical Supervision policy A&E records for the anger attack	April 2001
Examples of monthly team minutes	2000