NHS
East Midlands

An Independent Investigation into the Care and Treatment of a person using the services of Leicestershire Partnership NHS Trust

Undertaken by Consequence UK Ltd

Ref 2007/197

Date September 2010

This is the report of an independent investigation commissioned by NHS East Midlands to conform with the statutory requirement outlined in the Department of Health (DH) guidance *"Independent Investigation of Adverse Events in Mental Health Services"* issued in June 2005. The guidance replaces paragraphs 33 – 36 in HSG (94)27 (LASSL(94)4) concerning the conduct of independent inquiries into mental health services.

The requirement is for an independent investigation of the care and services offered to mental health service users (MHSUs) involved in adverse events, defined as including the commission of homicide, where there has been contact with specialist mental health services in the six months prior to the event.

The Independent Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd;
- Dr Mark Potter, Consultant Psychiatrist, South West London and St Georges Mental Health Trust; and
- Jane Jacobs, Independent Mental Health Nurse and associate, Consequence UK Ltd.

Acknowledgements

The Investigation Team wishes to thank the following for their assistance in the conduct of the investigation:

- the family of the victim, Ms V;
- the partner of the MHSU;
- the Major Crime Investigation Unit at Leicestershire Police;
- Leicester City Council Social Care Safeguarding Division (LCCSCSD); and

Leicestershire Partnership NHS Trust (LPT) and its staff

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List of acronyms used in the report

Acronym	Full Title
CMHT	Community mental health team
CPA	Care Programme Approach
CRHT	Crisis Resolution and Home Treatment service
CCSW	Childcare support worker
CPN	Community psychiatric nurse
CYPS	Children and Young People's Services
DH	Department of Health
IIT	Independent Investigation Team
LCC	Leicester City Council
LCCHTT	Leicester City Crisis and Home Treatment Team
LCCSCSD	Leicester City Council Social Care Safeguarding Division
LPT	Leicester Partnership NHS Trust
MHP	Mental health professional
MHSU	Mental health service user
PIER	Psychosis Intervention and Early Recovery team
RCA	Root cause analysis
SCIE	Social Care Institute for Excellence
SHA	Strategic Health Authority
SHO	Senior house officer

EXECUTIVE SUMMARY

Adverse event overview and intention

This report sets out the findings of the independent Investigation Team (IIT) regarding the care and management of a mental health service user (MHSU) by Leicester Partnership NHS Trust (LPT) for the period September 2006 to 3 January 2007.

In the morning of 3 January 2007 the MHSU left his home and went to a retail store in Leicester where he worked as a part-time contract cleaner. On arrival the MHSU approached the floor manager and asked to use the telephone. The floor manager dialed the requested number for him on the office telephone and the MHSU spoke with his employer, a contract cleaning company. The conversation was about how and when the MHSU was to be paid. After the phone call the MHSU was angry and left the office. The floor manager was then joined in the office by Ms V (the victim), one of the cashiers. After a short conversation about work matters, Ms V left to go to the cash office where she worked. A few minutes later the floor manager heard loud screams coming from the shop floor. She left her office to investigate and saw Ms V covered in blood running along the corridor towards her. Ms V subsequently died of injuries inflicted by the MHSU using a knife taken from items on display on the shop floor.

The MHSU was arrested for the attack and was taken into custody. On 25 January 2007 while in prison, and before his trial could take place, he committed suicide.

At the time of the event the MHSU had been receiving mental health services from LPT for a period of approximately four months.

Terms of reference

The terms of reference for the IIT were to undertake a targeted analysis of the care and treatment provided to the MHSU by LPT up to the date of the adverse event on 3 January 2007, in order to identify any relevant factors that might have predicted, altered or prevented the event. A separate investigation into the care and management of the MHSU between the time he was remanded into custody and his death had been undertaken by the Prison Ombudsman and was outside the remit of the IIT.

The key questions the IIT set out to answer were:

- Whether the care and management of the MHSU was reasonable in relation to:
  - the level of contact he received from the mental health service;
  - his medication management;
  - the degree of cultural awareness among the staff, including with respect to any language barrier issues;
  - his discharge from hospital;
  - his discharge from the Leicester City Crisis and Home Treatment Team (LCCHTT); and
  - the assessment and decision making undertaken by the Psychosis Intervention and Early Recovery team (PIER).

- Whether the mental health professionals were aware of child protection issues and whether they acted appropriately in relation to the safeguarding of children.

- Whether all professionals had a realistic and grounded appreciation of the risks presented by the MHSU, performed appropriate risk assessments and formulated appropriate risk management plans.
- Whether the attack on Ms V by the MHSU could have been predicted or prevented by the specialist mental health service.

Outline of the review process
The team conducted:

- A detailed and critical analysis of the MHSU's clinical records using timelining methodology.
- A critical appraisal of LPT's internal investigation report.
- Interviews with LPT staff who had direct contact with the MHSU.
- A meeting with Leicestershire Police and staff working with Leicester City Council's (LCC's) Children and Young People's Services (CYPS).
- A meeting with the then partner of the MHSU.

Main conclusions
Following a careful analysis of the MHSU's care and treatment by LPT and a consideration of the evidence collected by the Leicestershire Murder Investigation Team, the IIT concludes that the attack on Ms V on 3 January 2007 was not attributable to the MHSU's diagnosed mental health disorder or its management.

This appears to be a particularly unfortunate and tragic case. The evidence is that the delayed receipt of payment for his work as a contract cleaner was "the last straw" for the MHSU and that his general sense of frustration with life

erupted into a sudden, unpredictable and violent rage. In his anger the MHSU randomly attacked Ms V who had the misfortune to be in the vicinity and was simply going about her routine duties at her place of work.

The IIT concludes that the service the MHSU received from LPT was mostly of a good standard. In particular nothing has been identified that the mental health service could have done to either predict or prevent the event of 3 January 2007.

As with all investigations involving retrospective analysis, the IIT identified some aspects of the service provided to the MHSU and the interface communications between the various teams and agencies involved with him and his family that could have been improved.

These aspects were:

- The information provided to the LCCHTT by inpatient services and the MHSU's care coordinator at the time of his early discharge was inadequate. The team was not informed of the discharge plan or what was to happen after discharge from the LCCHTT service.
- On referral of the MHSU to the PIER team, information should have been given regarding the pre-admission risk issue of knife carrying for his personal safety. It was fortunate that the MHSU and his partner told the PIER team about this at the time of their first meeting on 27 October 2006.
- The discharge of the MHSU from the LCCHTT on 6 October 2006 represented unsafe practice. No MHSU should be discharged into a vacuum without awareness on the part of the nominated care coordinator of the discharge.
- CYPS should also have been notified of the MHSU's discharge from the LCCHTT on 6 October 2006 and of the delay in his assessment for PIER.
- It was good practice for PIER to provide CYPS with a report for the multi-agency family meeting. However it would have been more useful to CYPS if the report had detailed the factors leading to the MHSU's admission to hospital and his identified risk behaviours at that time.

While the above might have been managed better it does not alter the final conclusion reached by the IIT. Even if all the above had been addressed the evidence to hand indicates that the outcome on 3 January 2007 would have been the same.

Recommendations
The IIT has three recommendations for the specialist mental health service run by LPT in Leicester and one recommendation for LCC's Children and Young People's Services. All recommendations are locally focused and target the systems and processes that govern the standards of clinical care, and the interface between general adult services and the specialist mental health teams.

Recommendation 1: LPT must review the interface between operational policies of teams operating within Adult Services.
LPT must ensure that at minimum the operational policies pertaining to:

- inpatient services;
- community mental health services;
- Leicester City and Leicester County crisis resolution and home treatment teams;
- assertive outreach; and
- PIER

are reviewed in a coordinated and controlled way so that the interface between each is properly understood. Ideally the interface aspects of the protocols, or separate interface protocols, must be agreed between each service.

It must be clear in operational policies who is responsible for a patient's care at any time, especially at the point of discharge or transfer across services/teams. Operational policies must also describe clearly the steps needed to discharge this responsibility. An example of this would be:

"Patient A is being discharged from the PIER team and referred to the CMHT. The PIER team will retain responsibility until such time as a discharge/transfer meeting has taken place and a joint visit has taken place. If steps less than this are taken, e.g. inter team professional level discussion, this must be stated clearly in the clinical record. Until such time as either of these actions has occurred the PIER team will retain responsibility."

LPT must also ensure a system is in place to prevent individual teams from making ad-hoc changes to operational policies, which could create the opportunity for confusion to arise and allow a lack of consistent practice between teams that may lead to failings in care delivery.

Clear guidelines also need to be in place to manage disagreements between teams.

Target audience: LPT's Chief Operating Officer, all service managers responsible for the teams listed above.

Recommendation 2: LPT should improve its early discharge planning
This investigation identified that it is not the expected practice for LPT's crisis resolution and home treatment (CRHT) services to receive a copy of the discharge plan for a MHSU taken on for early discharge from inpatient services. Neither is it customary for CYPS to receive a copy of the discharge plan where there is known Adult Services and CYPS involvement within the same home.

CRHT services
If the provision of support at home by a CRHT service is an aspect of a discharge plan, it seems sensible to ensure that all parties to the plan have access to it. The CRHT service cannot be expected to meet the requisite quality standards unless provided with full and complete information when assuming the responsibility for the care of a MHSU. Consequently it is recommended with immediate effect that whenever a MHSU is accepted for early discharge then the CRHT team is provided with:

- a copy of, or access to, the discharge plan; and
- a copy of, or access to, the most up to date risk assessment.

Ref: "*Guidance statement on fidelity and best practice for crisis services*", DH, 2007

In adopting this recommendation LPT may wish the CRHT service to adopt the practice model currently used by PIER, namely going to the relevant team base and photocopying all previous records deemed important to have on PIER's independent file.

Note: The principles highlighted in this targeted recommendation apply to all discharge planning activities. They are not unique to early discharges.

Children and Young People's Services (CYPS)
LPT needs to look at the guidance it provides to its staff regarding the provision of information to CYPS when both agencies are providing a service to the same family. The IIT appreciates that mental health practitioners will have anxieties about this and the rights of the individual MHSU. However the Local Safeguarding Children Board for Leicester, Leicestershire and Rutland has a clear statement of intent in its practice guidance entitled "*Practice guidance adult mental health and child protection*". The former Department for Children, Schools and Families[1] also provided guidance on information sharing and recommended greater collaboration in working practices within and across agencies.

[1] Now the Department for Education

The need for collaborative working, particularly with respect to agencies working for the protection of vulnerable adults and children, must be addressed or at least referenced within all operational policies for LPT services.

LPT might also consider practical guidance on obtaining early consent from MHSUs for enabling effective and complete cross agency communication when necessary. In the immediate acute phase of mental illness this will not be appropriate and/or possible. However once a MHSU has been stabilised the discussion and formal obtaining of consent may be appropriate in many situations.

LPT must also ensure that professional staff working in Adult Services are fully conversant with the following publications:

- The Local Safeguarding Children Board's guidance on information sharing: *"Practice guidance adult mental health and child protection"* (2009).
- The Social Care Institute for Excellence (SCIE) publications, SCIE Guide 30: *"Think child, think parent, think family: a guide to parental mental health and child welfare"* (July 2009) and "*At a glance 9: "Think child, think parent, think family"* (July 2009).
- The Department of Health's guidance: "*Information sharing and mental health"* (September 2009).

Ideally LPT will develop its own local policy documents relating to these issues that effectively distil key practice principles and provide clear and accessible guidance to frontline staff.

Timescale :

CRHT services: For immediate consideration and implementation.

CYPS: The issue should be tabled for consideration by both the Corporate Governance and Safety Committee and the Governance Committee for Adult Services by September 2010. The expected outcome of these discussions is a clear action and development plan that will enable LPT to meet local and national safeguarding standards of practice.

Target audience: LPT's Chief Operating Officer, Service Manager for the CRHT teams (city and county), Service Manager for Inpatient Services.

Recommendation 3: LPT must achieve clear standards for discharging service users from CRHT services

The IIT is aware that LPT is presently undertaking a complete overhaul of the way the CRHT service operates across Leicestershire with a view to rewriting operational policy. The IIT has provided constructive feedback to the CRHT Service Manager in relation to the draft operational policy (2010) document. It is recommended that this feedback be formally considered for acceptance and incorporation into the final operational policy. Should a decision be made against inclusion of the feedback in the revised policy it is important that LPT is able to justify and articulate its rationale for that decision to the East Midlands Strategic Health Authority (SHA).

In particular the revised CRHT operational policy should set out clearly the standards expected when MHSUs are discharged from the CRHT service. Historically no such standards have been determined and to date no such standards are included in the draft operational policy (2010) document.

The IIT expects the standards to encompass all of the following:

- When discharge becomes a consideration and the MHSU is on a CMHT caseload, there will always be a discharge Care Programme Approach (CPA) meeting or, at minimum, a face-to-face meeting with the MHSU's care coordinator.

- If a discharge CPA or face-to-face meeting is not possible, the reasons for this are clearly documented in the MHSU's clinical records.

- When a service user is discharged back to primary care services (i.e. there is no continuing mental healthcare from specialist mental health services), a formal discharge summary is faxed to the MHSU's GP within 5 working days of discharge. The faxed summary will contain the same headings and content as a discharge letter from community or inpatient services. In the case of a planned discharge there should be no reason why this is not achievable.

Target audience: LPT's Chief Operating Officer, Service Manager for the CRHT teams (city and county).

Recommendation 4: For Leicester City Council's Children and Young People's Services (CYPS) need to consider producing a guidance note on core information it requires from other agencies in preparation for reports where professionals cannot attend for multi-agency meetings.

The IIT understands that CYPS is of the view that, when professionals and agencies from whom it would like to receive input reports are unable to attend for family support meetings or similar, it is unnecessary to provide them with outline guidance. CYPS believes that there is sufficient existing guidance provided by the policies and procedures of the Local Safeguarding Children

Board supplemented by the guidance issued by the former Department for Children, Schools and Families and the Social Care Institute for Excellence. However although safeguarding is very important, it is not the only issue that mental health professionals have to address.

The IIT has reviewed the available safeguarding documents and guidance. It is of the view that it would be beneficial and require minimal effort for CYPS to produce a simple guidance note that specifically addresses the information that should be included in reports provided by mental health services and other agencies.

This guidance could be a simple list as follows:

"In providing Children and Young People's Services with a report of the involvement of your services with Person A, it is helpful if you formulate the report under the following key headings:

- An overview of how Person A came to receive a service from you.
- An overview of current care and treatment.
- Any issues that impact upon child safety (risk of harm, neglect, alcohol or substance misuse, suicide risk etc, paranoid behaviours that may be frightening to a child etc).
- Any issues that may make a joint professionals' meeting useful to the effective care of the family."

Target Audience: Interim Divisional Director, Social Care & Safeguarding, Children and Young People's Services

Timescale :

The SHA must be advised of the position of CYPS within three months of the publication of this report.

1.0 INTRODUCTION

On 3 January 2007 the MHSU attacked and killed Ms V. He was subsequently arrested on suspicion of murder and remanded into custody awaiting trial and sentencing. On 25 January 2007, before the case was heard in court, the MHSU took his own life.

This investigation commissioned by East Midlands Strategic Health Authority is a statutory requirement under Department of Health guidance HSG(94)27 and its purpose is to determine:

- the quality of care and management afforded the MHSU; and
- whether or not the MHSU's attack on Ms V could have been prevented had he been managed differently by the LPT specialist mental health services.

1.1 Overview of the MHSU

The MHSU had no known mental health problems prior to 2006. His partner recalls that in early 2006 the MHSU obtained a cleaning post with a contract cleaning company. His hours of work were 7.30am until 9.30am. She recalls further that in June 2006 the MHSU began having problems with depression leaving him unable to work. This depression caused the MHSU to hallucinate at times and this put strain on their relationship.

The MHSU became reluctant to leave the house, believing that people were spying on him. He stopped helping out in the home and would act erratically. At about this time the MHSU's partner sought the advice of her child care support worker (CCSW) who advised that she contact her partner's GP. A week later the MHSU's partner again sought advice from her health visitor who reiterated the advice given by the CCSW.

Consequently on 7 September 2006 she contacted the MHSU's GP and a referral was made by the GP to the LCCHTT, a specialist mental health team managed by LPT.

At this time the MHSU's baby son was four weeks old.

1.2 Overview of the MHSU's contacts with specialist mental health services in Leicester

Following assessment of the MHSU at home on 7 September by the LCCHTT, a decision was made that he required hospital admission to enable a longer period of assessment. The assessing mental health professionals also formed the opinion that the MHSU presented too high a risk to himself and others to be suitable for intensive support at home. At this time he had taken to carrying a knife with him for protection.

The MHSU was admitted to hospital on 7 September. Over the following 13 days the MHSU presented no challenges to the inpatient team. He was initially commenced on 5mg of olanzapine (an anti-psychotic medication) and his psychosis and paranoia settled quickly. Although initially withdrawn and not particularly talkative the clinical records document that from 11 September the MHSU began to open up to the inpatient staff. He was noted to be in better spirits but remained socially isolated, concerned that "fellows on the ward keep to themselves" and feeling that others "see him differently". The records document that he believed that someone was going to attack and strangle him.

By 15 September the MHSU was expressing a wish to have home leave as he was missing his son and was worried about how his partner would be coping with the children. A day's home leave was arranged for 16 September and according to the clinical records and the MHSU's partner this went well.

During the in-patient period there were no risk management issues presented by the MHSU. He was:

- quietly spoken;
- polite;
- kept himself to himself; and
- complied with his treatment plan.

This presentation was in keeping with his partner's experience of him over the preceding three years and also the experience of CYPS over the preceding months.

The MHSU and his partner both expressed a wish for him to be discharged. The MHSU missed his family and believed he was needed at home. His partner was finding it difficult to manage their three month old son and her toddler daughter by herself. Consequently the MHSU's consultant psychiatrist agreed to early discharge on 20 September with support being provided by the LCCHTT service in the first instance.

Between 20 September and 29 September the MHSU received regular home visits by the LCCHTT. He was discharged from the team on 3 October 2006.

The plan at the time of the MHSU's discharge from the LCCHTT was for him to undergo a period of assessment by PIER, the early intervention service. At this time PIER had a waiting list and the MHSU's care coordinator (consultant psychiatrist) was advised that the MHSU needed to be provided with an interim care package by the appropriate community mental health team (CMHT). Although the MHSU was nominally placed on the CMHT caseload he was not assigned a community psychiatric nurse (CPN). The MHSU therefore had no contact with mental health services for a period of three weeks following his discharge from the LCCHTT.

On 27 October the PIER team commenced its assessment of the MHSU. At this time the MHSU told the team that he needed to talk about his experiences in his home country. He appeared willing to engage and wanted treatment. However the progress notes document that the MHSU had stopped taking his medication because he did not think he needed it. The assessing mental health professional (MHP) discussed this with him and encouraged him to restart his medication which he agreed to do.

Because the MHSU was not available to meet with the PIER team before 6 November and his MHP was on annual leave during that week, a further appointment was made for 13 November.

On 6 November the CPN nominally assigned to the MHSU at the Maidstone CMHT contacted PIER advising that the team intended to discharge him from its caseload. The PIER team requested that this be deferred until its assessment had been completed and a decision made regarding eligibility for ongoing care and management by PIER, and the MHSU was not discharged.

On 13 November the PIER MHP attended the MHSU's home but he was not in. A subsequent appointment was therefore made for 26 November.

On 15 November the challenges of conducting a full assessment of the MHSU were discussed at the PIER multidisciplinary team meeting. The team decided to extend the assessment period to enable it to properly determine his eligibility for their service. The plan was to maintain contact with the MHSU's consultant psychiatrist during this period and also to contact his GP to see if he had details of any previous psychiatric treatment. The MHP assigned to his assessment was tasked with making contact with CYPS to find out the details of any safeguarding issues. There is no record of whether or when CYPS was contacted.

On 17 November the PIER MHP tried unsuccessfully to contact the MHSU on the telephone. On 20 November a further unsuccessful attempt was made and a message was left asking him to make contact.

On the same day the MHSU's consultant psychiatrist contacted the PIER team to find out what was happening and was told of the difficulties making contact with him. She suggested that the PIER team speak with CYPS as it may have been aware of the family situation through its close contact with the MHSU's partner.

On 22 November the PIER MHP spoke with the MHSU on the telephone. The MHSU said that he had been busy and that he was looking after his child. His partner also spoke with the MHP and advised that the MHSU had not been taking his medications. However, she also reported that he had now got more olanzapine from his GP and that the dosage had been reduced to 2.5mg

because of side effects the MHSU had been experiencing, namely increased lethargy and difficulty getting out of bed in the morning.

The PIER MHP advised the MHSU that he should continue with his medications and that she would visit him on 27 November.

On 23 November the PIER team spoke to the MHSU's GP. The GP advised that the MHSU had only been registered with the surgery since September 2006 so they did not have any historical information about him.

On 24 November a further home visit took place. The MHSU had not been eating and was noted to have lost weight and looked tired and pale. He said he was taking his olanzapine at a dosage of 5mg daily. In the course of the assessment the MHSU talked about the voices he reported hearing prior to his admission to hospital in September, saying that they were his own thoughts about himself. The MHSU was naturally concerned for the welfare of his son.

The assessment record also noted that the MHSU continued to wait for the outcome of his asylum appeal. He continued to believe that people talked about him when he went outside which made him anxious so that he preferred to stay indoors.

The plan following this assessment was to make a decision regarding the MHSU's suitability for the PIER caseload at the multidisciplinary meeting on 4 December. On that date the MHSU was assessed by a staff grade doctor working with the PIER team. Also present were the MHSU's PIER care coordinator, his partner and his son. The assessment record notes that things had not been the same since the MHSU's admission to hospital. He continued to feel that people in the estate had changed their attitude toward him. It was not entirely clear at this time whether these beliefs represented over-valued ideas, or delusions.

On 6 December the MHSU was taken onto the PIER caseload. Although his diagnosis remained unclear there continued to be evidence of some degree of paranoia and depressive symptoms.

On 8 December the MHSU made a telephone call to his PIER care coordinator. He was at home with his partner and children. He was noted to be in good spirits and he reported that he had put on weight.

On 11 December the PIER care coordinator faxed a report to CYPS in readiness for a planned family meeting that she was unable to attend.

On 18 December the MHSU did not attend a scheduled outpatient appointment. His care coordinator intended to visit him at home the same week and did in fact try and visit him the same day. The MHSU was not at home but the care coordinator spoke to his partner who said that the MHSU

was out working as a cleaner. It seems that this was the MHSU's first day back at work. His partner also told the care coordinator that the MHSU was OK and was taking the prescribed medication. A home visit was agreed for 28 December and subsequently confirmed in writing to the MHSU.

On 28 December the care coordinator met the MHSU at home with his partner and children. The record notes that he was in good spirits and had put on weight. He said he was well but stressed out about his asylum appeal, that it was always on his mind and left him feeling confused. On being asked about his background the MHSU told his care coordinator that his father was a general in the army and was murdered for political reasons. This caused his family to splinter and he fled to the UK. The MHSU reported having "terrible memories that caused him pain". He also spoke about his cultural isolation in Leicester. During this visit the MHSU's mental state appeared stable and no evidence of psychosis was observed. The next home visit was agreed for 5 January 2007, one week later.

The risk assessment completed after this visit identified that the primary risk presented by the MHSU was one of self-harm. A potential child protection risk was also identified, for the reason of lack of parenting skills rather than any violence or direct harm concerns. The risk assessment stated that the MHSU had not voiced any plan or intent to harm himself or others.

On 3 January the incident at the retail store occurred.

1.3 The adverse event

In the morning on 3 January 2007 the MHSU left his home and went to the retail store in Leicester where he worked as a part-time contract cleaner. On arrival the MHSU approached the floor manager and asked to use the telephone. The floor manager dialled the requested number for him on the office telephone and the MHSU spoke with his employer, a contract cleaning company. The conversation was about how and when the MHSU was to be paid. After the phone call the MHSU left the office. The floor manager was then joined in the office by Ms V, one of the cashiers. After a short conversation about work matters, Ms V left to go to the cash office where she worked. A few minutes later the floor manager heard loud screams coming from the shop floor. She left her office to investigate and saw Ms V covered in blood running along the corridor towards her. Ms V subsequently died of injuries allegedly inflicted by the MHSU using a knife taken from items on display on the shop floor.

Please go to Appendix 1, page 71, for a more detailed chronology of the MHSU's contacts with the statutory mental health service in Leicester.

2.0 TERMS OF REFERENCE

The terms of reference for this independent investigation, set by East Midlands Strategic Health Authority (the SHA), were as follows:

"To undertake a systematic review of the care and treatment provided to the MHSU by Leicestershire Partnership NHS Trust (LPT) to identify whether there was any aspect of care and management that could have altered or prevented the events of 3 January 2007.

The IIT is asked to pay particular attention to the following:

- The quality of the health and social care provided by the Trust to the MHSU and whether this adhered to Trust policy and procedure, including:
  - to identify whether the Care Programme Approach (CPA) had been followed by the Trust with respect to the MHSU;
  - to identify whether the risk assessments of the MHSU were timely, appropriate and followed by appropriate action, including consideration of children's safeguarding arrangements;
  - to examine the adequacy of care plans, delivery, monitoring and review including standards of documentation and access to comprehensive records;
  - the Mental Health Act assessment process (if appropriate)."

To ensure that the above were explored appropriately the following questions were agreed with the SHA:

- Whether the care and management of the MHSU was reasonable in relation to:
  - the level of contact he received from the mental health service;
  - his medication management;
  - the degree of cultural awareness among the staff, including with respect to any language barrier issues;
  - his discharge from hospital;
  - his discharge from the Leicester City Crisis and Home Treatment Team (LCCHTT); and
  - the assessment and decision making undertaken by the Psychosis Intervention and Early Recovery team (PIER).
- Whether there were appropriate clinical handovers and communications between the mental health teams involved and also with Children and Young People's Services.

- Whether all professionals had a realistic and grounded appreciation of the risks presented by the MHSU, performed appropriate risk assessments and formulated appropriate risk management plans.
- Whether the attack on Ms V by the MHSU could have been predicted or prevented by the specialist mental health service.

In addition to the above the IIT was asked:

- To establish whether the recommendations identified in the Trust's internal investigation reports were appropriate and to determine the extent of implementation of the action plans produced by the Trust in response to these recommendations.
- To identify any learning from this investigation through the use of root cause analysis (RCA) tools and techniques as applicable.
- To report the findings of this investigation to East Midlands Strategic Health Authority.

3.0 CONTACT WITH THE FAMILY OF MS V AND THE FAMILY OF THE MHSU

The IIT first made contact with the husband of Ms V on 26 November 2009 and subsequently on 11 January 2010 and 4 March 2010. It was agreed with Mr V that a meeting would be organised on completion of the investigation report in draft so that the findings could be shared with Mr V.

Mr V also nominated issues to the IIT in writing which he hoped the investigation could accommodate.

These issues were:

- ❒ Is the claim that the MHSU had a mental illness genuine?
- ❒ If so, how can this be proved?
- ❒ Could the crime have been prevented if sufficient care/service was in place?
- ❒ Is any one particular person or team to blame? If yes, what is being done about it?

All these questions were already embraced within the terms of reference agreed between the IIT and East Midlands Strategic Health Authority.

Arrangements were made to meet with Mr V on 5 May to advise of the investigation's findings and to provide answers to his questions.

The IIT also made contact with the partner of the MHSU and met with her and her child care support worker on 15 March 2010.

She was informed in written correspondence of the findings of the investigation with the support of her social worker. If following this she wished to again meet with the investigation team, it was agreed that she would advise the IIT via her child care support worker.

4.0 FINDINGS OF THE INVESTIGATION

This section of the report sets out the independent Investigation Team's (IIT's) findings in relation to the following questions.

- (4.1) Whether the care and management of the MHSU was reasonable in relation to:
  - (4.1.1) the level of contact he received from the mental health service;
  - (4.1.2) his medication management;
  - (4.1.3) the degree of cultural awareness among the staff, including with respect to any language barrier issues;
  - (4.1.4) his discharge from hospital and his discharge from the Leicester City Crisis and Home Treatment Team (LCCHTT); and
  - (4.1.5) the assessment and decision making undertaken by the Psychosis Intervention and Early Recovery team (PIER).
- (4.2) Whether the mental health professionals were aware of any child protection issues and whether they acted appropriately in relation to the safeguarding of children.
- (4.3) Whether all professionals had a realistic and grounded appreciation of the risks presented by the MHSU, performed appropriate risk assessments and formulated appropriate risk management plans.
- (4.4) Whether the attack on Ms V by the MHSU could have been predicted or prevented by the specialist mental health service.

These sections are presented on the following pages:

4.1 Was the care and management of the MHSU reasonable?

Overall the care and management of this MHSU was reasonable. He received an appropriately thorough assessment on 7 September 2006 and the decision to admit him to hospital was the right thing to do. His subsequent wish to be discharged home was managed appropriately and safely via the early discharge route and the decision by his consultant psychiatrist to ask the PIER team to assess him for suitability for their service was sensible.

During his hospital stay he received appropriate assessment and attention from the medical and nursing staff. Of particular note was the effort undertaken by the MHSU's consultant psychiatrist and her team to try and make successful contact with the MHSU's family, members of whom were reported as living in London. Successful contact was made with a woman reported to be the MHSU's cousin. However the person contacted would not speak with the medical staff about the MHSU.

The mental health staff were aware of potential child safety issues and made appropriate enquiry regarding this. Communication took place between the specialist mental health service and CYPS before the MHSU's discharge home and it was confirmed that from the perspective of specialist mental health services there were no safeguarding issues. Further communications between CYPS and specialist mental health services occurred when the MHSU was being assessed by the PIER team.

With respect to cultural issues all of the mental health teams who had contact with the MHSU were aware of his asylum status and the avenues available in Leicester to provide additional support to him if that was required. All staff were also mindful of potential language issues. However, for this MHSU, speaking and understanding English was not problematic.

The decision of the PIER team to undertake an extended assessment of the MHSU between October and November 2006 before making any decision about his suitability for their service was also good practice.

There were three aspects of the MHSU's care and management that could have been better. These were:

- ❒ The poor quality of information provided to the LCCHTT by inpatient services when the decision was made for early discharge from hospital.
- ❒ Lack of timely notification by the LCCHTT to the MHSU's consultant psychiatrist regarding the decision to discharge him from the service.
- ❒ The need for a broader perspective on the relevant information to be shared between the two agencies involved with the MHSU and his family, namely specialist mental health services and CYPS.

However the weaknesses identified above did not have any adverse impact on the overall care package delivered to the MHSU. In particular they did not adversely affect the assessment of the MHSU by the PIER team who had responsibility for his care and management between October 2006 and 28 December 2006, the period of time leading up to the incident.

4.1.1 The level of contact the MHSU received from the mental health services

The MHSU was admitted to the acute psychiatric inpatient unit on 7 September 2006 and was discharged from this service on 20 September 2006.

After this he received the following contacts from mental health services.

Table 1: Contacts with the MHSU 20 September – 3 January 2007

Date	Time gap in between contacts	Team	Nature of contact	Successful or unsuccessful contact (i.e. did the mental health practitioner get to speak with or meet with the MHSU?)
20/10/06	Daily contact	CHRT	Face-to-face	Successful
21/10/06			Face-to-face	Successful
22/10/06			Face-to-face	Successful
24/10/06			Telephone	Successful
25/10/06			Face-to-face	The MHSU was not at home in the morning so an evening visit was provided. The evening visit was successful.
28/10/06	3 days[2]		Face-to-face	Successful
3/10/06	4 days		Face-to-face	The MHSU was not at home in the morning so an evening visit was provided. The MHSU was discharged from CHRT at this visit.
4/10 – 26/10/06	No contact with mental health services for 24 days.			
27/10/06		PIER	Face-to-face	Successful

[2] Note the CRHT care plan says that alternate day visits are required.

Table 1 continued: Contacts with the MHSU 20 September – 3 January 2007

Date	Time gap in between contacts	Team	Nature of contact	Successful or unsuccessful contact (i.e. did the mental health practitioner get to speak with or meet with the MHSU?)
31/10/06	4 days		Telephone	Successful but MHSU advises that he is not available to meet again with PIER until 6 November. A visit is agreed for 13 November.
13/10/06	13 days	PIER	Face-to-face	Unsuccessful. MHSU not in.
17/11/06	4 days	PIER	Telephone	Unsuccessful
20/11/06	3 days		Telephone	Unsuccessful – message left for the MHSU to make contact with the PIER team.
22/11/06	2 days		Telephone	Successful. Note: there had been 22 days between successful contacts.
24/11/06	2 days		Face-to-face	Successful
04/12/06	11 days		Face-to-face	Successful
08/12/06	4 days		Telephone	Successful
18/12/06	10 days		Outpatient appointment	The MHSU did not attend for this.
18/12/06			Face-to-face	Unsuccessful – update obtained from partner of MHSU.
28/12/06	10 days		Face-to-face	Successful. Note however that there were 20 days between this and the last contact which was by telephone.

The contact table shows that reasonable efforts were made to be in contact with the MHSU between 20 September and 28 December 2006. Furthermore immediately prior to Christmas the CCSW to the MHSU's partner saw him and his family. She told the IIT that she made sure that they had all of the CYPS contact numbers and all relevant mental health contact numbers for the MHSU. Her colleague also visited the family over the Christmas period. The CCSW recalls that both the MHSU and his partner appeared relaxed, ready for Christmas and looking forward to it.

There were however four occasions where there were periods of 10 days or greater in between attempted contact with the MHSU. These occasions were:

- 4 October – 26 October
- 31 October – 13 November
- 8 December – 18 December
- 18 December – 28 December.

The 13-day gap between the 31 October and 13 November is not of concern because the reasons for this are clear. Firstly the MHSU could not meet with the assigned PIER MHP before 6 November. Secondly, annual leave within the PIER team prevented a date being diarised for a meeting with the MHSU before 13 November.

The 24-day gap between 3 October and 27 October is of concern, not because of any particular risk to the MHSU in not having contact with mental health services during this period, but because no one was aware of it at the time. This issue is explored further in section 4.1.4, page 30 of this report.

The 10-day period between 8 December and 18 December is not of concern for two reasons:

- A 10-day gap in between assessments for service users who are presenting as well is not remarkable.
- Assessments of the MHSU were planned for the 18 December. The MHSU did not attend for his outpatient appointment and neither was he at home when his care coordinator attended in an attempt to meet with him there.

What is of concern however is the further 10-day gap following these missed appointments until the next scheduled appointment on 28 December. This was a MHSU who at this time remained a largely unknown entity for the specialist mental health services. Because he had been referred to and accepted by the PIER service, one might have expected an appointment to have been offered, or further attempts at telephone or face-to-face contact in advance of 28 December. When asked about this the MHSU's care coordinator told the IIT that the 10-day gap would have been caused by staff being on annual leave over Christmas coupled with bank holidays. PIER at that time did not operate on bank holidays. There was contact with the MHSU's family on 18 December at which point no concerns were raised. Furthermore it was assessed that the MHSU did not need or want any follow up over the holiday period. Consequently an appointment was made for as soon after Christmas as was possible. The IIT was satisfied with this explanation.

A review of the contact CYPS was having with the family at this time showed that there was contact with the MHSU and his partner on:

- 4 December at a home visit;
- 8 December at a home visit; and
- 12 December with the MHSU's partner at the family support meeting (the MHSU did not attend).

No concerns were identified regarding the MHSU at either of these home visits.

4.1.2 The MHSU's medication management

There is nothing notable about the medication management for the MHSU. He was commenced on a low dosage of 5mg olanzapine on 7 September. His consultant psychiatrist was very aware that it was a low dosage.
She told the IIT that it seemed to be sufficient and that the MHSU settled very quickly and "his thought disorder settled/subsided, and the voices settled". The consultant psychiatrist also told the IIT that because of the speed with which the MHSU's symptoms settled it was questionable whether the medications prescribed had had any impact on this at all. However she and the IIT agreed that because they had settled it would not have been sensible at such an early stage to have reduced or stopped his medication.

During the period of contact with the PIER team there were two documented occasions when the MHSU reported not taking his medication. On both occasions he was encouraged to restart his medication. The IIT notes that the LPT internal investigation report criticised the PIER MHPs for not advising the consultant psychiatrist about the MHSU's reported non-compliance and the IIT explored this with her. The consultant psychiatrist said she was quite satisfied with the PIER input and that "they have a good working relationship, they communicated with her, they followed up the medication non-compliance as she would have expected a CMHT to do". Had the MHSU persisted with medication non-compliance, the PIER MHP told the IIT that she would have contacted his consultant psychiatrist. However the MHSU subsequently told her that he was taking it and this was confirmed by his partner. The consultant psychiatrist was quite clear that, for isolated episodes of medication non-compliance, she would not expect to be notified if the visiting MHP had successfully negotiated a solution with the MHSU.

The IIT concludes that the actions of the PIER MHP and the perspective of the consultant psychiatrist were reasonable.

4.1.3 The degree of cultural awareness in the staff, including any language barrier issues

On analysis of the clinical records a clear assessment could not be made regarding the level of awareness in relation to the MHSU's cultural needs, his needs as an asylum seeker and any language issues he might have. However it was noted that the LPT's internal investigation report raised the failure to provide the MHSU with an interpreter as problematic.

The IIT explored these concerns in interviews with all mental health professionals but did not confirm them. The overwhelming evidence is that the MHSU had a very reasonable command of the English language and this was corroborated by his partner and CYPS. There was therefore no need for interpreter services.

The following is typical of the information imparted to the IIT:

"The crisis team is culturally aware regarding the needs of asylum seekers. In 2007 the team was very positive in the recruitment of ethnically diverse professionals and therefore the team had and has a wide variety of language skills. The consultant psychiatrist to the crisis team has also done quite a bit of work with the Assist Project. This is a project that works with asylum seekers." A city crisis team MHP.

"The translator service – yes can get access to this easily. I didn't feel the MHSU needed a translator, neither did he. With regards to his asylum status – I believed that he already had legal representation for this. If he had needed more support we could have signposted him to other services such as the Red Cross. However this was not required, he was legally represented.
I would have considered referral to other services if the MHSU had no legal representation, or was unclear about his rights as an asylum seeker, or his applications. In terms of cultural isolation, I had already made enquiries regarding Ugandan services the MHSU could access and would have pursued this in the fullness of time had our contact with him continued. The MHSU had let us know that he had family and relatives living in London and that he was in contact with and had visited them. He found this comforting as it gave him access to his own culture." The MHSU's PIER care coordinator.

All professionals spoke of the Assist Project in Leicester as the appropriate resource for advice and direction in dealing with any MHSU seeking asylum in England.

The IIT concludes that there was no lack of cultural awareness or sensitivity among the LPT staff. On the contrary, all were alive to the potential issues and well informed about the available resources to address them if required.

4.1.4 The MHSU's discharge from hospital, and from the city crisis team

4.1.4.1The discharge from hospital

The MHSU was discharged from hospital under the early discharge scheme and into the care of the LCCHTT on 20 September 2006. This decision was in itself reasonable.

The MHSU's consultant psychiatrist told the IIT that the MHSU's main preoccupations were getting home to see his children and to help with their care. He was concerned that his partner might not cope and his son would be taken into care. The consultant psychiatrist recalled speaking with CYPS and said that her understanding was that they saw the MHSU as a stabilising influence in the home for his child and also his partner's daughter. In an ideal world the consultant psychiatrist would have kept him in hospital longer to enable a fuller assessment – she was aware that his partner could/might put pressure on him. The consultant psychiatrist recalled that the partner noted that the MHSU was getting better and wanted him home. However it was clear that the MHSU also wanted to go home and would, in her opinion, go home. Therefore a planned early discharge seemed more appropriate.

The IIT concludes that the decision for planned early discharge was reasonable. The MHSU was an informal patient and, on the evidence to hand including his documented improvement while in hospital, there would have been no grounds for detaining him under the Mental Health Act. He did not display any worrying behaviours or express any thoughts that might raise concern that if acted on would put himself or others at risk. In all the circumstances a planned early discharge with the support of the crisis team was an appropriate course of action.

What was unsatisfactory however was the absence of a clearly documented plan for the MHSU's care after discharge. The inpatient multidisciplinary review form completed when the decision for early discharge was made is as follows:

- "Early discharge;
- to continue olanzapine;
- to contact child social services re the MHSU's discharge."

There is no information in the inpatient record to indicate that the consultant psychiatrist's plan was a referral to PIER. The last notation in the progress notes says:
"The MHSU has been discharged following Early Discharge Planning assessment outcome. His partner came to pick him up. TTO given. Out patient appointment to be arranged and sent to him".

A discharge letter was dictated on 2 October and typed on 5 October, 15 days after discharge, and records the discharge plan as:

- "The MHSU will be seen in outpatients.
- The MHSU will have early discharge support and continued monitoring of his mental health.
- The MHSU has been referred to the PIER team."

Review of the PIER records revealed that the PIER team received the relevant referral form for the MHSU on 14 September 2006, six days before the MHSU's early discharge to the LCCHTT. There is therefore no reason why this could not have been documented on the discharge plan or in the records of the multidisciplinary review that took place the day before the MHSU's discharge.

Because the LCCHTT staff involved in the early discharge assessment of the MHSU no longer work for LPT it was not possible to find out whether there had been any verbal communication about the planned referral to PIER. However, those LCCHTT staff who remain as employees of LPT reported that they rarely if ever receive a copy of the discharge plan for service users referred for early discharge. Further, they reported that referrals to LCCHTT are always verbal and it is not routine practice to expect or to ask for faxed written referrals.

The consultant psychiatrist also told the IIT that:
"To my knowledge the system has always been that referrals for EDP are either rung through to LCCHTT or, when there was a link nurse attending ward rounds, given to him/her at the time. The LCCHTT staff would come to the ward, complete their assessment and paperwork after seeing the patient, talking to staff and looking at inpatient notes. I do not think there has ever been any formal written referrals or even a requirement to send a copy of the discharge care plan."

Page 16 of LPT's "*Crisis and home treatment operational policy",* under the header "Link practitioner", says:

"There is a clear agreed plan, involving the Crisis Team, preferably from the ward round, of what is to be achieved from CRHT involvement, who the care will be passed on to and expected time scale."

The IIT understands that the link practitioner role worked with variable success and that at the time the MHSU was discharged there was no link practitioner involvement. The MHSU did however receive an assessment from the LCCHTT on 20 September, the day of discharge, and before being accepted for early discharge. However there is no documentation setting out what the expectation of LCCHTT involvement was other than to facilitate a managed discharge for the MHSU given his eagerness to go home.

The IIT is concerned that LCCHTT staff are not being involved at a sufficiently early point in the discharge planning process in order to make their input meaningful. The current process for patient referral to the LCCHTT for early discharge does not seem adequate. The events surrounding the early discharge of the MHSU do not satisfy what the IIT considers to be good practice standards for discharge planning. The IIT is aware that LPT is currently consulting on a revised process for early discharge which includes the formulation of standards.

The "*Guidance statement on fidelity and best practice for crisis services"*, (DH 2007, a joint publication between DH, NIMHE and CSIP) is not explicit regarding measurable standards for early discharge. However the extract detailed below does imply an expectation that CRHT services have clear systems and standards in place.

"Features of early discharge
Early discharge means discharge at a time earlier than would happen if intensive home treatment was not available and is still part of an acute episode of care. Facilitating early discharge remains a core function of the work of CRHTs and it is recommended that teams develop a systematic approach to providing this.

Having been involved in all admissions (through the gatekeeping role), the team is in an ideal position to identify the reasons for admission and through close working relationships with the inpatient unit systematically review whether these reasons continue to exist, and what needs to happen prior to the individual being discharged. If for some reason (and against best practice) an individual had been admitted without CRHT involvement, there is no reason why the team should not play a role in facilitating early discharge. But this process is likely to work best if there has been earlier contact between the service user and the team."

Ref: "*Guidance statement on fidelity and best practice for crisis services",* DH, 2007 (joint publication between DH, NIMHE and CSIP). Pp. 4-5.

The other issue that emerged when exploring the process of hospital discharge was in relation to the communications between inpatient services and CYPS. The MHSU's consultant psychiatrist told the IIT that CYPS was fully aware that the MHSU had been in hospital and was going home. CYPS has confirmed that this was indeed the case and that the consultant psychiatrist telephoned herself to advise of his discharge. It was further advised that no safeguarding issues had been identified by the inpatient staff during the time the MHSU had been in hospital.

CYPS expressed the view that some form of written communication detailing the circumstances of the admission and the outcome of the mental health assessments would have been helpful to it in its safeguarding role. It considered that receiving more rounded information about the MHSU rather than information only considered to be of direct relevance to the safeguarding of the children would have been useful. It might have assisted CYPS in providing support to both the MHSU and his partner, including giving an insight into those behaviours mental health services would have wanted to be informed about, such as medication non-compliance.

The IIT understands from the MHSU's consultant psychiatrist that the reason CYPS was not given an opportunity to attend a discharge planning meeting was because of the early discharge. She suggested that an alternative approach would have been to send the MHSU home on home leave, and then recall him for a full discharge planning meeting with all relevant teams and agencies in attendance. This, the consultant psychiatrist considers with the benefit of hindsight, may have been a better approach. However she was of the view that this alternative, if adopted, would not have added substantially to the MHSU's care package or made any difference to subsequent events. The IIT is in agreement with this conclusion.

4.1.4.2The discharge from the crisis and home treatment team

The IIT considers that the process of the MHSU's discharge from the LCCHTT was completely unsatisfactory for the following reasons:

- There was no clear discharge plan at the multidisciplinary review meeting on 27 September some six days prior to discharge.
- No member of the LCCHTT contacted the MHSU's care co-ordinator (his consultant psychiatrist) to advise that he was being discharged.
- The LCCHTT was unaware that the plan was for the MHSU to be assessed by the PIER team and that the PIER team had advised the MHSU's care coordinator that it could not undertake this for a number of weeks and therefore alternative support would need to be provided to him.

A discharge summary was completed by LCCHTT on 16 October, 13 days after the MHSU had been discharged. The summary was received by the MHSU's consultant psychiatrist on the same day and was the first notice she had of his discharge from the LCCHTT. Although there is no evidence to suggest that the three week period in which the MHSU had no contact with mental health services was disadvantageous to his mental health, in different circumstances such a lengthy interval without contact may have been problematic. The IIT sought information about audit data gathered by LPT's CRHT services. At the time under consideration and up to the present, the discharge process for a MHSU is not subject to any audit. The IIT was informed that there is regular record keeping analysis by team leaders on an ad hoc and informal basis, without the use of pre-determined indicators.

The IIT considers that there can be no confidence that aspects of CRHT practice that should be subject to retrospective review are being recorded and reviewed in a way that would enable LPT's CRHT service to evidence attainment of any stated quality standards.

With regard to the particular standards for discharge and what happened in this case, it cannot be said that the LCCHTT deviated from the operational policy governing its practice as the section entitled "*Discharge*" only states:

"7.18 The CRHT will inform all necessary services, family/carers of the decision to discharge or refer on the other services, if a request for further support networks has been identified." (Page 9 of the 2006 policy).

Under Section 9, "*Staffing*", (a completely unrelated section to discharge practice), under the subheading "*Link worker*", the operational policy states:

"The criteria for someone to be discharged early from the ward to home via the Crisis Team would be:

The expected involvement of the Crisis Team would be less than 14 days. Initially the visits would be no more than once a day, being tapered down over the two weeks. The risk assessment indicates that solo visits would be safe. The level of support needed is such that STR and Development Workers would be used (non-registered staff).

There is a clear agreed plan, involving the Crisis Team, preferably from the ward round of what is to be achieved from CRHT involvement, who the care will be passed on to and expected time scale.

Toward the end of CRHT involvement a joint visit is made with the CPN, if CMHT is to be involved, a handover and an on-going plan is formulated, preferably in the home." (Page 16 of the 2006 operational policy).

It is not clear why this last paragraph is not also linked to the standards for all discharges regardless of whether they follow a period of home treatment as an alternative to admission, or under the early discharge scheme.

The service leaders were not able to give an explanation for the lack of clear standards for discharge against which team performance could be audited. The lack of comprehensiveness in the CRHT operational policy raises questions about the robustness of the governance systems and processes in place at the time. It also raises questions about the Trust's corporate approach to ensuring that all operational and clinical policies follow a standardised format and are subjected to an appropriate level of scrutiny before final ratification. Exploring this further is not, in the IIT's opinion, valuable this length of time after the incident and the original policy development. What is important is for LPT to ensure a clear procedure by which all policies are developed, scrutinised and ratified. Where there are two "same type" teams (for example, the CRHT for Leicester City and the CRHT for Leicester County), then either a single operational policy should govern both teams or, if that is not possible, there must be agreement about the core content of each team's operational policies. This principle also applies to the operational policy for CMHTs. There should be one operational policy for all CMHTs with personalisation on an as-needed basis only.

The IIT was pleased to learn from the service manager for the CRHT service that the city and county teams are currently working on a unified operational policy. The IIT was invited to comment on the draft document and has provided feedback to the service manager for incorporation into subsequent versions of the unified policy. The IIT has been informed by the service manager for the CRHT services in LPT that they have, following comment from the IIT, already incorporated into the draft operational policy the following:

In the section on discharges:

“All decisions for discharge should be MDT [multidisciplinary team] ratified”.

“Discharge plans should state clearly that the teams providing follow up care are in agreement with this and the plan should provide contact details for future reference”.

Both these quality markers are auditable. The IIT is aware that the management team for the CRHT service in LPT is already putting together a rolling audit tool for completion at the point of service user discharge. The audit data will be used in individual staff supervision as well as to audit whole team performance.

4.1.5 The assessment and decision making undertaken by the Psychosis Intervention and Early Recovery (PIER) team

The MHSU was accepted onto the PIER team's case load on 6 December 2006 for an extended six month assessment period. He had originally been referred to the PIER team on 14 September and his first contact occurred on 27 October 2006.

The MHP assigned as the MHSU's care coordinator told the IIT that:
"There was uncertainty about the MHSU's diagnosis, there was some paranoia, so we took him onto the caseload for a six month extended assessment. I took him on as care coordinator. The staff grade and other PIER medics are always included in the assessment process from the beginning. Discussions will have taken place as to the MHSU's suitability as a referral and the outcome of any meetings with him.
The MHSU was physically assessed by the staff grade/medic, prior to the team making the decision about his suitability for treatment, as all our referrals are."

The IIT considers that the retention of the MHSU on the PIER team's caseload reflected good practice.

With regard to the period of time preceding his acceptance onto the PIER caseload:

- The MHP (PIER 1), assigned to assess the MHSU when he was first referred, wrote to his consultant psychiatrist advising that PIER could not accept the MHSU for assessment owing to a four to six week waiting list. The letter clearly advised that if ongoing contact with mental health services was required then the MHSU should be managed by the relevant CMHT, or other relevant service, until such time as the PIER team could commence the assessment process. This communication was clear and represented good practice.
- When the PIER team was able to commence its assessment process a home visit was made by two MHPs on 27 October 2006. The clinical record of this assessment was comprehensive and evidenced that the MHPs obtained an insight into:
    - the MHSU's family background;
    - the MHSU's reported experiences of persecution and torture;
    - his social and emotional stressors, in particular his fears regarding the well being of his family, in his home country, and his concerns regarding his social isolation in Leicester;
    - the precursors to his hospital admission on 7 September 2006; and

- the circumstances of the MHSU's partner and the situation with her children.

This assessment was cut short owing to the MHSU's preoccupation with the two children present, precluding further meaningful assessment of his mental health state at that time. A further appointment was offered the following week to complete the assessment but the MHSU was unavailable until the week of 6 November. Unfortunately this coincided with annual leave for PIER 1 so an alternative date of 13 November for continuing the assessment was agreed.

- On 13 November the MHSU was not at home for his planned home appointment. As no-one was at home a message note was left offering a further appointment for 27 November. Following this unsuccessful visit PIER 1 discussed the difficulties in completing the assessment in the PIER weekly team meeting on 15 November. The team agreed that the assessment should be pursued and that the MHSU's consultant psychiatrist should be informed and kept informed. This decision was appropriate.

- Between 17 and 21 November a number of attempts were made to contact the MHSU with positive contact finally being made on 22 November by telephone. During this call his partner came to the phone and informed PIER 1 that the MHSU had not been taking his medication but that he now had a repeat prescription from his GP. She also said that the MHSU had reduced his dosage of olanzapine to 2.5mg owing to side effects. PIER 1 recalls, and recorded in the clinical records, that she told the MHSU's partner that he "should take his medication as prescribed." PIER 1 also advised the MHSU's partner that she and her colleague PIER 2 would visit the MHSU on 27 November. This action by PIER 1 was reasonable.

- The planned visit actually took place on 24 November. The MHSU was at home. At this visit PIER 1 and PIER 2 were able to explore with him the antecedents to his admission into hospital, that the reason why he had taken an excessive dose of ibuprofen was "to make himself feel better", not to harm himself. The MHSU said that he had heard voices but on further questioning he described these as "his own thoughts about himself". The MHSU was noted as feeling "better" since discharge from hospital but that he felt "controlled by his partner". The PIER record notes that the MHSU felt as though "people talk about him when he is outside but was unable to explain why". The MHSU reported feeling anxious when he was outside, preferring to stay inside. A clear plan was agreed at the end of this assessment which was:
  - for the MHSU to attend for a medical assessment on 4 December; and

- for the PIER team to decide whether or not the MHSU was suitable for their service.

- The MHSU attended on 4 December accompanied by his partner and his four month old son and a thorough review of his current and recent past presentation was undertaken. The MHSU's stressors at the time were clearly identified and a mental state examination performed. As a result of this assessment the clinical impression was that the MHSU did suffer from paranoid psychosis, but was not overly psychotic; and the differential diagnosis was paranoid depression.

  The plan was for a further clinic based review, to determine what realistic support could be given, to discuss the MHSU's situation at the next multidisciplinary PIER team meeting, and make a firm decision regarding any continuing input for him from the PIER team. The IIT considers the assessment undertaken on 4 December to have been thorough and appropriate based on what was known about this MHSU at the time. It did include the MHSU's isolated episode of carrying a knife.

- On 8 December CYPS advised PIER 1 that there was a family meeting and requested her attendance. PIER 1 was unable to attend but agreed to submit a report of the PIER team involvement with the MHSU. At this time PIER 1 was informed by CYPS that the MHSU's child was subject to a family support plan because of previous parenting issues relating to the child's mother, not the MHSU. In the opinion of the IIT this was an appropriate communication, and PIER 1 did what one would expect of a MHP in providing CYPS with a report in lieu of her personal attendance at the planned family meeting.

- On 10 December the PIER team decided that although the MHSU's diagnosis was unclear, he was experiencing continuing paranoia and depressive symptoms. He was therefore appropriate for its service and the next steps were to engage further with him and formulate an appropriate care package for him.

- On 18 December the MHSU did not attend for his review appointment. PIER 1 had attended at his home to transport him but he was not there. His partner told PIER 1 that the MHSU was out working, that he needed to for money, that he was OK and taking his medication. It was agreed that PIER 1 would make contact with the MHSU to schedule another appointment. A letter was sent the following day offering an appointment on 28 December at 11.30am.

- On 28 December the rescheduled home visit took place as planned. The MHSU was noted to be “in good spirits” and to have “put on weight”. However he told PIER 1 that he remained stressed about his asylum appeal. There is no information to suggest that his stress levels were over and above those one would expect for an individual in the MHSU’s situation. At this visit PIER 1 began to explore the MHSU’s background with him. He told her about his father and that he was “murdered for political reasons”[3]. The MHSU also told PIER 1 that he felt culturally isolated since coming to the UK. From a mental health perspective PIER 1 observed no evidence of psychosis and assessed the MHSU’s mental state as stable. A further home visit appointment was made for 5 January 2007.

Comment by IIT

The IIT can find no aspect of PIER’s involvement with the MHSU that was unreasonable. The MHPs made appropriate efforts to make and keep in regular contact with the MHSU. When they were successful in doing so their contemporaneous records reveal the level of exploration of past and current circumstances that one would expect of an early intervention psychosis service. At interview the PIER MHPs were able to recount clearly their understanding of the MHSU’s issues and his risk vulnerabilities and stressors. The plan for further detailed assessment and the formulation of a package of care for the MHSU was a reasonable one. The IIT cannot see that the PIER team should have conducted itself differently in the relatively short period of contact it had with the MHSU.

[3] As a result of the police investigation it is now known that the MHSU was not honest about his personal circumstances in Uganda.

4.2 Whether the mental health professionals were aware of any child protection issues and whether they acted appropriately in relation to the safeguarding of children

The IIT found that staff were aware of safeguarding issues and that there was timely communication with CYPS to find out whether there were issues that mental health services needed to be aware of. The evidence for this is contained in the clinical records and was recounted during individual interviews with the IIT.

At the time of the MHSU's discharge his consultant psychiatrist spoke with CYPS to inform it of the MHSU's planned discharge, and that during his inpatient treatment staff had not identified anything that might constitute a safeguarding concern.

The child care support worker (CCSW) who had the most input with the MHSU and his partner with regard to the children told the IIT:
"It was the CCSW's impression that the MHSU clearly wanted to be there for his partner, to support her. The CCSW recalled that he told her that he had a daughter in his home country but had not been involved in the parenting. He appeared very keen to be a parent. The pre-birth core assessment concluded that both partners were engaging and both had demonstrated a willingness to work with the local authority. It was a very positive assessment. It was a cohesive assessment – the couple were working together. Both were keen to be successful parents.

There was a pre-birth child protection conference which was informed by the assessment undertaken – this recommended that the unborn child was not at risk of significant harm and therefore there was no recommendation made for the child to be placed on the child protection register at birth."

The CCSW also told the IIT that:
"It was recognised by all agencies that the MHSU and his partner needed support to care for the children and so the pre-birth conference concluded with a recommendation that the baby was made subject to a family support plan. The plan was comprehensive and included participation by both health/education and social care staff. The purpose of the plan was to give the MHSU and his partner the support they required to safely care for their children. Both parents were in full agreement with the recommendation."

The CCSW also told the IIT that:
"At discharge the impression the CCSW had was that the MHSU was suffering some sort of psychotic episode and had maybe suffered post traumatic stress following the birth of the baby. There was some inference of post-natal depression triggered following the birth of his son. He was discharged from hospital by his consultant psychiatrist. She did contact the CCSW via telephone to advise them of his discharge, and that the psychiatric service had not identified any safeguarding issues with him and that he would be referred to LCCHTT and they would be visiting him every other day. The MHSU would also have access to a 24 hour helpline. They (mental health services) would continue to support the MHSU but while he was in hospital he was polite/friendly and showed that he was worried about his partner and the children."

The consultant psychiatrist told the IIT that she had:
"observed the MHSU with the children on the ward and he interacted well with them – there was no evidence of any risk to them."

The PIER clinical records clearly evidence awareness about possible child safety concerns and PIER 1 told the IIT that:
"She got in touch with the childcare support worker and had regular dialogue about this family, support plans and what was in place, family support services. She also provided a written report for the family support meeting in December. This was sent to the CCSW when she could not attend the family support meeting."

Although the IIT considers that the specialist mental health professionals acted appropriately with regard to safeguarding children there was one point of contention between CYPS and mental health. This relates to the breadth of information CYPS would like to receive from mental health services when both agencies are providing an input to the same household.

A manager for CYPS told the IIT:
"If there is evidence that adult social care are involved in a family where Children's Services are also involved I would expect the following:

- ❒ Communication between allocated workers.

- ❒ Invitations to multi-agency meetings convened by either agency in order to share information and co-ordinate a holistic and comprehensive assessment action plan or risk assessment if risk have been identified by either agency (adults or children).

- ❒ Any significant information to be shared outside of meeting times via phone/email."

On the whole these standards were met in this case. There was communication between the MHSU's consultant psychiatrist and CYPS and also between PIER and CYPS. There was a lapse in communication at the point of discharge from the LCCHTT (see section 4.1.4 page 30). However, this was not specific to CYPS.

The communication from PIER 1 to CYPS appears to have been reasonable.

The MHSU's consultant psychiatrist and PIER 1 were invited to a family services meeting on 12 December 2006.

The MHSU's consultant psychiatrist responded to her invitation advising that she could not attend the meeting. It would have been optimal practice if she had provided CYPS with a report about the MHSU.

PIER 1, who also could not attend the meeting at short notice, wrote a detailed report for the family support meeting. The report was forwarded to the CCSW on 8 December.

The report set out the involvement of PIER with the MHSU. However it did not set out the historical context of how the MHSU came to be receiving mental health services or identify any of the risk issues. Because of the purpose of the family support meeting and the previous conversations PIER 1 had had with the family's social worker, she did not appreciate the range of information that CYPS finds helpful to receive. The IIT explored this with PIER 1. She explained that she had been asked to attend the family meeting at very short notice. When she advised that this was not possible she was asked to inform CYPS of her team's involvement with the client. To her recollection she believes that CYPS was satisfied with the information she provided at the time. When advised that CYPS would have liked more information about previous contact between the MHSU and mental health services, PIER 1 told the IIT that it would have been helpful if CYPS had provided some outline guidance as to their requirements, ideally as an outline template document. PIER 1 said further that she had not had time to discuss with the MHSU disclosure of his mental health issues and could not provide extensive information to social services. She did however; provide information she considered to be relevant and necessary for the family meeting.

Currently CYPS does not provide agencies such as mental health with guidance on or a format for a report of their involvement with a family. It is assumed that because the individuals with whom social service are liaising are professionals they will know:

- the type of information required; and
- how to format a report.

The IIT suggests that this assumption may not always be correct. Outline guidance for inclusion with the template correspondence inviting professionals to family and other relevant meetings may be worthwhile. The perspective of CYPS is that the *"Think child, think parent, think family"* guidance and the protocols on information sharing contained within the document entitled *"Practice guidance adult mental health and child protection"* from the Local Safeguarding Children Board for Leicester are adequate.

Section 5 of the latter document, titled "*Importance of inter-agency working* [4]" says:

"5.1 Adult mental health professionals and childcare social workers, school nurses, health visitors and midwives and education services and other agencies as appropriate must share information in order to be able to assess risks. This includes the sharing of information around a parent's past experience of psychiatric services, not just about current involvement. Children's workers need to seek out such information and adult mental health workers need to see it as their role to provide this information when requested. Please refer to Chapter 2: Information Sharing in the local LSCB Procedures. If more than one adult service is involved, then both should work closely together, e.g. if both parents known to services, or if they are known to drug or alcohol services, forensic or personality disorder services as well as an adult psychiatry service. They should also gather relevant information from any police, housing or probation workers involved. Some particularly vulnerable adults may also be subject to the local multi-agency policy and procedures for the protection of vulnerable adults from abuse. Details of these procedures are available on the websites of the three local authorities.

5.2 Care Programme Approach (CPA) meetings about mentally ill parents must include consideration of needs and risk factors for the children concerned. In all such cases Children's Social Care must be involved in planning discharge arrangements.

[4] http://www.lscb-llr.org.uk/index/guidance/guidance_adult_mh_child_protection.htm#importance_of_interagency_working

5.3 Child Protection Strategy meetings and Child Protection Conferences must include any psychiatrist, community psychiatric nurse, psychologist and adult mental health social worker involved with the parent/carer."

For mental health professionals there are many considerations when deciding what information to share with another agency, even one that is working with the same family. The recently published best practice guidance *"Information sharing and mental health"* (DH 2009) will help staff in their considerations around information sharing. In addition to this document all mental health professionals working with MHSUs who are parents of children under the age of 18 years should be fully conversant with the following publications:

- The Local Safeguarding Children Board's guidance on information sharing: *"Practice guidance adult mental health and child protection"*.

- The Social Care Institute for Excellence publications, SCIE Guide 30: *"Think child, think parent, think family: a guide to parental mental health and child welfare,"* (July 2009) and "*At a glance 9: Think child, think parent, think family."* (July 2009)

4.3 Whether all professionals had a realistic and grounded appreciation of the risks presented by the MHSU, performed appropriate risk assessments and formulated appropriate risk management plans

On the evidence available to it, the IIT is of the view that, during the period of contact from early September to end December 2006, mental health services (LCCHTT, inpatient services, the PIER team) had a realistic and grounded appreciation of the MHSU's risk profile. Except for his reported behaviour of carrying a knife with him following the birth of his son, which, coupled with his expressed thoughts of harming himself, formed the basis for the decision to admit him to hospital, there was nothing in his known history, or in his observed and reported behaviour as a hospital inpatient and then in the community over a period of four months, to generate concerns regarding harm to others or to suggest that the MHSU was prone to outbursts of violence. The evidence was rather of a gently spoken man who was a calming influence on his partner and a dedicated father to his child and stepdaughter.

There were however, some aspects of the clinical record keeping could have been more complete.

Documents completed about the MHSU that specifically reference risk were completed on:

- 7 September (crisis assessment and admission assessment);
- 14 September (detailed referral form sent to PIER);
- 20 September (LCCHTT assessment regarding the MHSU's acceptance for early discharge);
- 27 October (PIER assessment form);
- 16 November (LPT initial risk screening tool); and
- 28 December (Sainsbury Centre for Mental Health risk screening tool).

4.3.1 Risk records completed to the expected standards of good record keeping

The documents completed on 7 September, 27 October, 16 November and 28 December appropriately recorded the MHSU's pre-admission and current (i.e. present at the time) risk issues. In keeping with expected and good practice the PIER documents also included an appropriate risk contingency and crisis plan for the MHSU.

The crisis assessment – 7 September

The crisis assessment document completed on 7 September 2006 was very thorough and clearly identified that the MHSU was "experiencing auditory hallucinations of a command nature as well as of a derogatory nature". The clinical record states: "The voices are telling the MHSU to kill himself also he believes that people are watching him and also being racist to him. He has taken out knives from the cupboard for protection against these people." The

MHP who conducted the assessment clearly recorded: “I feel that the risk of harming himself and/or others is high at the moment and the MHSU is therefore currently not suitable for home treatment.” The completed risk screening form also evidences the appropriateness of the MHP’s caution and decision at this time. A full risk assessment was a recommendation of the initial screening and this was also completed on 7 September. This form states “has been carrying a knife for protection but reports he would not harm anybody”. At this time there was no information available via the police, social services, or the MHSU’s partner that suggested anything contrary to this.

The PIER assessment – 27 October

The LPT “*Interagency care programme approach and assessment and outline care plan*” document initiated on 27 October by PIER 1 records the MHSU’s pre-hospital admission presentation in depth. Her record clearly identified the range of risk factors for the MHSU as:

- Cultural isolation.
- Social withdrawal, limited social network.
- “Prior to admission reportedly took an overdose of ibuprofen tablets (exact amount unknown) prior to admission. The MHSU denied this initially and then admitted that he ‘may have done’ but reported it was only 10-14 tablets.”
- “Reported thoughts of carrying weapons to protect himself from perceived threats. The MHSU denied this and there has been no evidence to suggest that he is currently thinking of carrying weapons.”
- Poor diet/self neglect.

PIER 1 concluded: “During the assessment the MHSU presented with no identifiable risks and was considered to be of low risk of self harm or harm to others. He did not express any deliberate self harm ideation. He denied any previous harm towards others and expressed no current plans or thoughts of harm towards others.”

The PIER assessment – 16 November

This document is a simple risk screening tool that is largely in tick box format. It is completed on the basis of current presenting risk at the time, not historical risk. At the time of completion PIER 1 was of the view that the MHSU presented no behaviours suggestive of a risk of harm to others. PIER 1 also noted that there was no expression of concern from others such as his partner and CYPS about risk of harm.

These perspectives are underpinned by the following:

- At interview the MHSU’s consultant psychiatrist expressed the opinion that “the knife issue was associated with the paranoid ideas and that all settled while the MHSU was an inpatient”. She inquired about but elicited no history of violence. The MHSU’s partner “said

there had been no violence or aggression in the time she had known him".

- CYPS told the IIT that: "An assessment of the MHSU was undertaken by social services once they became aware that his partner was pregnant. The impetus for the checks was as a result of the challenges his partner had previously faced in being able to successfully parent her children. The checks did not show anything untoward." The checks did include contacting the local police to see if the MHSU was known to them and checking social care records within the local authority.
- The CCSW who had most contact with the MHSU and his partner told the IIT that the MHSU was "a very quiet calmly spoken chap, no histrionics". She said that in her experience the MHSU only ever displayed normal first time father anxiety – "'Will I be a good dad', 'What will I do if she goes into labour' etc" – he wanted things to be right. The CCSW said further that she never felt at risk around the MHSU, there were simply no identifiable risk factors that emerged about him. She had had frequent contact with the MHSU's partner and believed that, had there been issues such as violent and aggressive behaviour, the partner would have informed her of this and she would have seen a change in the older child's behaviour. The following quote from the interview with CYPS encapsulates its perspective of him:

  "The CCSW recalls him as being polite, and respectful. His partner could be agitated but not him. He, the CCSW observed, managed to deflect his partner's agitation."

The CCSW's recollection is validated by PIER 1 who said that the "general impression from the social worker was that the children's mother was rather dominant but that the MHSU was a stabilising factor in the family unit. They had no concerns regarding the relationship".

The PIER risk assessment – 28 December

This was a comprehensive document completed following a home visit where the MHSU, his partner and child were present, and formulated on the basis of consultation with both the MHSU and his partner. This is expected and good practice.

The primary risk identified was self-harm. This was because of the previous overdose with ibuprofen.

Other risks identified were that his child was at the time under the care of the Northfields Social Services team following historical concerns regarding the MHSU's partner's parenting skills.

The following table represents the information recorded relating to violence and aggression.

Table 2: Aggression/violence

Issue	Y N D/N	Issue	Y N D/N
Previous incidents of violence	❒ ❒ ✓	Paranoid delusions about others	✓❒ ❒
Previous use of weapons	❒ ❒ ✓	Violent command hallucinations	❒ ✓ ❒
Misuse of drugs/alcohol	✓ ❒ ❒	Signs of anger and frustration	❒ ✓ ❒
Male gender under 35yrs	❒ ✓ ❒	Sexually inappropriate behaviour	❒ ✓ ❒
Known personal trigger factors	❒ ✓ ❒	Preoccupation with violent fantasy	❒ ✓ ❒
Expressing intent to harm others	❒ ✓ ❒	Admissions to secure settings	❒ ✓ ❒
Previous dangerous or impulsive acts	❒ ❒ ✓	Denial of previous dangerous acts	❒ ✓ ❒

PIER 1 also notes that the "history was difficult to obtain due to language barriers. The MHSU is a poor historian and previous history is denied. PIER is unable to follow up his history as he is an asylum seeker. He initially presented with paranoia about his neighbours talking about him".

Under the heading "*Situational context of risk factors*" the notes record PIER 1's view that: "There are no identifiable risks which currently indicate the need for two workers."

The summary records:
"The MHSU has experienced 1st episode psychosis and has displayed paranoia towards his neighbours. This paranoia appears to relate towards his race/colour. The MHSU has not expressed any plans/intent of harm towards himself or others. He is currently engaging with the PIER team and whilst he has difficulty communicating his needs due to language barriers he is accepting of treatment. His partner has a history of risk towards health professionals but there is currently no evidence of risk towards staff from the MHSU or his partner."

On the basis of review of the record and the interview with PIER 1 and her colleague, the IIT considers that these MHPs undertook as thorough an assessment of the MHSU as could be expected and that they developed an appropriate risk management and relapse prevention plan for the MHSU.

The issue of "language barriers" referred to above was further explored in interviews with the PIER team. The IIT was given to understand that by this

term the PIER team meant the reduced range of the MHSU's English vocabulary rather than any significant limitations in his ability to understand English or to communicate effectively on a day-to-day basis. PIER 1 also advised the IIT that the use of the term "language barriers" was to remind her colleagues to use simple "plain English" rather than complex vocabulary. It had been her experience, and that of CYPS, that if one did this then the MHSU was able to understand clearly what was being said, what was being asked and what was expected of him. The IIT has suggested to the PIER professional who made the record that to avoid potential retrospective misinterpretation of clinical records, it is better to state precisely the issue rather than using generalised language that is open to misinterpretation.

The MHPs have described a problem the MHSU had in communicating with them which may have been addressed if he had been able to use the wider vocabulary of his native language through the use of an interpreter with a wider English vocabulary than he had. Although in this case the information gathered about the MHSU suggests that he would not have been more forthcoming about his background and prior experiences, another mental health service user might. For another service user, access to relevant interpreting services (even though their command of the English language may be satisfactory) may elicit information of value to their effective mental health care and treatment that otherwise may be lost.

4.3.2 Risk records where the standard and accuracy of the record keeping could have been improved

The documents the IIT was less satisfied with were those completed on 14 September and 20 September 2006.

Referral form sent to PIER - 14 September

The referral form is detailed, to ensure robustness in the information provided by referrers to its service.

The form was completed by the senior house officer (SHO) to the MHSU's consultant psychiatrist and on the whole it is reasonably completed. The section detailing the MHSU's presentation provides information about:

- the MHSU's asylum status;
- the MHSU's pre-admission presentation in relation to hearing voices, seeing people that are not there, feeling that people are talking about him;
- the MHSU's self neglect and lack of sleep;
- suicide ideation and self harm thoughts; and
- cannabis use which the MHSU reported stopping 5-6 months ago.

It does not communicate to PIER that the MHSU had been carrying a knife for self protection, immediately prior to his admission to hospital, and that it was this specific behaviour that led to the crisis assessor's decision that home

treatment was not appropriate. Furthermore the responses in the section of the form entitled "*Indicated risks*" are negative for all except suicide attempts, which is annotated with "prior to admission".
Under the heading "Any other risks you have identified", the recorded response is "nil".

The IIT expected that the MHSU's known knife carrying and related thoughts would have featured on this form, and that the anomalies in his history of cannabis use might also have been highlighted. The MHSU reported to some professionals that he had not smoked cannabis since the birth of his son, i.e. three months previously, to others he said five to six months. Although this discrepancy would not have altered the clinical management of the MHSU it may have alerted clinicians to the possibility of other inconsistencies.

The final piece of information that could have been more accurately detailed relates to the MHSU's living arrangements. The inpatient records note that he was not particularly happy with his partner and found her to be controlling, but that he was worried about the well-being of his son. It may also have been useful to the PIER team to know that there were long standing parenting issues with the MHSU's partner and that CYPS were actively engaged with the family. In this respect other agencies were involved with the MHSU. This section of the PIER referral form was left blank.

Crisis team record - 20 September
The LCCHTT form completed on 20 September was not as thorough as that of 7 September. In some respects this can be explained on the basis that the earlier document was readily accessible so that it was reasonable to complete some parts of the later form briefly. However section 3 of the form relating to "*Deliberate self harm*" states that there was no history of this, an inaccuracy since there had been concern about an ibuprofen overdose prior to his hospital admission.

Furthermore section 1 of the risk assessment component records that there was no history of aggression and that there was no concern for others. While there was no free text space on the form for the notation of behaviours that might pose a risk of harm to others, the IIT considers that this may have been an appropriate section in which to record the pre-admission behaviour/thoughts of knife carrying. The failure to record this at all in the risk assessment is not satisfactory.

A senior MHP (at the relevant time) for the LCCHTT informed the IIT that this issue was picked up by the LCCHTT team leader and addressed with the MHP who undertook the assessment.

4.4 Whether the attack on Ms V by the MHSU could have been predicted or prevented by the specialist mental health service

The IIT has concluded on the basis of the evidence to hand that there was nothing in the information available to CYPS or the specialist mental health services, at the time of last contact with the MHSU on 28 December 2006, that should have alerted them to a heightened risk that the MHSU might cause serious harm to another person.

The MHSU's partner had been in a relationship with him for 3-4 years and had found the MHSU to be a gentle man. Over this period of time he had never shown the slightest aggression towards her or her daughter. This view was corroborated by CYPS who had known the MHSU's partner since she was 15 years of age, and her biological family. They had also been involved with the MHSU's partner in connection with her previous four children.

It is true that the MHSU's history prior to his arrival in England was unknown. However even if known the IIT considers that it is unlikely, in the context of his observed behaviour and demeanour, that the MHSU would have been considered to represent a risk of harm to others within the context of the very different life he was living in England. That life was not without ongoing legal, financial and other challenges, but the MHSU had managed to live with these for some time without resort to violence.

The MHSU did for a time prior to his hospital admission on 7 September 2006 carry a knife for self-protection. However the evidence is that this was an isolated episode. He stopped carrying a knife when requested to do so and there is no evidence that before this time he had been a regular carrier of knives or other weapons. His partner was not aware of any such behaviour and never had cause prior to his acute psychotic illness to feel unsafe around him. The weapon used to inflict the injuries on Ms V was a knife. However, it was not one carried by the MHSU but one selected at random from sale items on display on the retail shop floor.

The IIT's conclusion is that this was a sudden and uncharacteristic act of violence on the part of the MHSU using as a lethal weapon a knife that presented itself readily to hand in the vicinity. It was perpetrated in a rage triggered by personal circumstances relating to the MHSU's pay and at random against a victim who had the misfortune to present a target by her mere presence in the vicinity. As such it could not have been foreseen or prevented by the mental health services responsible for the MHSU's care.

5.0 THE INTERNAL INVESTIGATION CONDUCTED BY LPT (AUGUST 2007)

It was a requirement of the terms of reference for this investigation for the IIT to comment on LPT's internal investigation conducted between 2007 and 2008. The IIT were provided with LPT's internal investigation report entitled Root Cause Analysis Investigation into the care of X SAE –953 STEIS 2007/197. This document was dated August 2008. The watermark embedded in the document stated that this document was a draft report. It appears that this was never removed.

The investigation commissioned by the senior management in LPT comprised an extensive investigation panel. The members of this were:

- LPT's Director of Nursing and Therapies;
- a consultant psychiatrist;
- the Assistant Director of Quality Assurance, Leicester City Primary Care Trust;
- a National Patient Safety Agency patient safety manager;
- a clinical nurse manager from Rampton Hospital;
- a modern matron (adult psychiatric services);
- LPT's General Manager for Specialist Services; and
- LPT's Team Manager, Forensic Mental Health Services.

The reason why the panel comprised such a range of skills was because the terms of reference included the analysis of the MHSU's care and management up to the time of his suicide on 25 January 2007.

The panel identified 14 potential concerns associated with the care and management of the MHSU. The concerns ranged from documentation issues during the MHSU's inpatient episode through to the lack of safe discharge of the MHSU by the LCCHTT in October 2006.

Based on a review of the internal investigation documents and its own investigative findings the IIT does not believe that all of the internal panel's statements about identified concerns can be supported by the available evidence.

The concerns the panel identified with which the IIT it does not wholly agree are as follows.

"Inadequacy in the assessment of the MHSU when he was admitted to the inpatient ward."

Specifically the investigation panel noted:

- "a lack of attention to his personal and cultural background;
- the possibility of post traumatic stress disorder (PTSD);
- suicide risk; and

- knife carrying".

IIT comment
The medical assessment at the time of admission was acceptable. It highlights the difficulties in obtaining information from the MHSU and that informant history was obtained from the LCCHTT assessment and the MHSU's partner.

The assessment clearly states "denies thoughts of DSH/suicide ideation, but girlfriend heard him vomiting two days ago- had taken O/D of ibuprofen. Says took them for relief".

The assessment record also states: "Yesterday – knife (knives) found on table. Had thoughts of carrying them for protection. No thoughts of hurting others. No history of assault."

The nursing "*Interagency Care Programme Approach assessment Adult Acute Services*" says: "He feels nobody likes him he describes what could be thought insertion thoughts coming into my head that I will be harmed. He states he carries knives for protection. He states he feels confused."

When the IIT first reviewed the clinical records it too considered the possibility of a diagnosis of PTSD. This was specifically explored in interviews with all staff substantially engaged with the MHSU. As a result the IIT is satisfied that as the MHSU's presentation and triggers for his psychosis became better understood, the PIER professionals did indeed consider the possibility that PTSD may have been a factor.

What could and should have been improved was the clarity of the discharge care plan and also the immediate risk management plan for the MHSU.

"Incomplete and inaccurate risk assessment on admission to the inpatient ward, including no risk assessment in relation to his visitors, including his children."

IIT comment
The risk assessment conducted was reasonable overall and the documentation was average. The criticism as stated in the internal investigation documents is, in the opinion of the IIT, a little harsh.

There were no indications that the MHSU's family were at risk and it would have been good practice for the professional completing the risk document to have stated this clearly. There was also a typing anomaly in relation to the MHSU's risk factors but this is obvious when reading the document and would not have been misleading.

The aspect of the form that should have been more informative was section 12, "*Accommodation and environment*". It simply states: "Lives with his girlfriend and 2 children. It is her flat."

The IIT would have expected some information relating to lifestyle and also the involvement of social services with the children.

The above being said the assessment does capture that the MHSU found fatherhood overwhelming; that he had problems with concentration and poor sleep; that he had some paranoid ideation and had become reluctant to leave the house; that he heard voices of people threatening him; that he felt protected by his children; and that at the time of the assessment his "responses were slow" and he was not forthcoming with information.

As stated above what could and should have been improved was the documented short term plan of care to address the identified risk issues for the MHSU.

"There was a failure by <u>all</u> agencies caring for Mr X to refer him to the appropriate agencies e.g. psychology; Asylum Agency."

IIT comment
This criticism if made would have been unjust. The MHSU was a failed asylum seeker. He had legal representation and was having his appeal supported by his local MP. He was in safe accommodation and functioning in a family unit. For the few months mental health services were in contact with the MHSU there was no reason to refer him to an agency such as the Red Cross.

The IIT considers that a referral of the MHSU to psychology services would have been premature. The PIER team did not have a firm diagnosis and was working towards an in depth understanding of the MHSU's needs and issues, aware that there may be factors in his past that would need to be addressed in due course. The IIT is of the view that referral to psychology services at this early stage would not represent routine practice.

"No follow up by staff after the MHSU had stopped taking his prescribed medication on 27 October 2006."

IIT comment
The clinical records evidence that the PIER team advised the MHSU to take his medication and liaised with his partner on this issue and that medication compliance was discussed when the PIER team next met with the MHSU. The consultant psychiatrist to the MHSU is noted to have been satisfied with the approach the PIER team took.

“The MHSU’s partner was not involved in his assessment/risk assessments.”

This criticism if made would have been unfounded. The clinical records clearly document that the MHSU’s partner was present during the initial crisis assessment and also during subsequent assessments conducted by the PIER team. The detailed medical assessment on 4 December and risk assessment on 28 December were performed with his partner in attendance. There are additional clinical entries that highlight open communication with the MHSU’s partner.

The IIT agrees that there is no evidence that the MHSU’s partner was offered a carer’s assessment, however in mitigation she was very well supported by the CYPS team which was also in contact with the PIER team. It is highly unlikely that any issues that required joint working would not have been picked up.

ACTIONS TAKEN BY LEICESTERSHIRE PARTNERSHIP TRUST FOLLOWING THIS INCIDENT

The following details the actions completed following the acceptance of the Trust's internal investigation report and its recommendations in August 2008.

Recommendation	IIT's perspective regarding the appropriateness of the formulation of the recommendation	Progress to date
Work needs to be undertaken on the ward to ensure adherence to the Trust assessment standard including other relevant documentation e.g. admission paperwork. MDTs need to ensure that the documentation is reviewed regularly on ward rounds.	The first five recommendations needed more focus and some direction as to what work was required. Ideally SMART (Specific, Measurable, Achievable, Realistic and Timely and Targeted) criteria should be applied.	Guidance was issued to staff via training and all care plans are personalised to the Service User. There has been a general move away from core care plans across LPT. Recommendation fully implemented as part of a larger piece of work across inpatient services.
Work needs to be undertaken to ensure appropriate allocation of Primary Nurse to meet individual patient's needs.		As above

Recommendation	IIT's perspective regarding the appropriateness of the formulation of the recommendation	Progress to date
Work needs to be undertaken to ensure that any gaps in Risk Assessments and Care Plan documentation are picked up and addressed.	As above	There are regular Essence of Care audits which look at risk assessments and their quality. Service Users are involved in this programme. The Essence of Care audits occurs on an annual basis.
Work needs to be undertaken to ensure accurate and complete Risk Assessments in relation to visitors including children. Ensure Adherence to Child Visiting Policy.	As above	The review of risk assessments is a key element of clinical and management supervision. Risk assessment documentation is also assessed as a core component of CPA audit.
Work needs to be undertaken to ensure clear Clinical leadership.	As above – what work is required and by whom and in what service?	The whole of adult inpatient services has been reconfigured. All inpatient wards have a matron, who is a band 7 practitioner. Furthermore there is also a deputy chief nurse, and a range of Band 8 practitioners who also provide clinical leadership.
Work to be undertaken to ensure clarity of roles and responsibilities of Primary and Associate Nurses.	With this recommendation we know that the clarity of role needs to be improved for inpatient primary nurses (i.e. the named nurse for the patient).	The time to care initiative and the reconfiguration of inpatient services has created the opportunity for greater clarification of staff roles and responsibilities.

Recommendation	IIT's perspective regarding the appropriateness of the formulation of the recommendation	Progress to date
Work needs to be undertaken to develop therapeutic relationships and ensure that the environment is conducive to Service delivery.	These two recommendations are very vague and not helpful.	LPT has a releasing time to care programme operating in the Trust. This has enabled both of these recommendations to be addressed.
Work needs to be undertaken to ensure a proactive approach towards recruitment and rostering of staff.		
Work needs to be undertaken to ensure that Risk Assessments and Care Plan documentation take into account and demonstrate how we meet individual patient's needs.	This recommendation is better. The Trust should be able to evidence remedial work in relation to the quality of risk assessments and the extent to which they reflect the needs of the individual.	This issue has been addressed via educational sessions, clinical and management supervision and the considerable development work LPT has undertaken in the redevelopment of its care plan tools and also in the over Trust approach to personalised care planning.

Recommendation	IIT's perspective regarding the appropriateness of the formulation of the recommendation	Progress to date
Work needs to be undertaken to ensure a robust system of handover between shifts and members of the ward team.	This recommendation should also have included the crisis team. However, robust standards for discharge we hope were generated as a result of this.	
Work needs to be undertaken to ensure clear Trust Policy and guidance relating to drug screening on admission.	This recommendation is reasonable. It could have defined what work was required.	The Trust now has a new policy on drug screening that has been approved and implemented.

Recommendation	IIT's perspective regarding the appropriateness of the formulation of the recommendation	Progress to date
Work needs to be undertaken to meet the needs of BME service users and asylum seekers, including the use of interpreters and developing an understanding of their experiences and how this may impact on their mental health.	The IIT found LPT staff very aware of interpreting services and how to access them. One issue LPT staff need to bear in mind is that in the context of the mental health discussion with service users, "everyday" competency with English may be insufficient to enable the depth of discussion required to properly understand a service user's mental health needs. Consequently staff must be mindful of the value of discussing with a service user referral for interpreting services even where "everyday" communications appear satisfactory.	Although this recommendation was not accepted as there was no basis in the internal investigation's findings for it LPT are part of the community rights and inclusion programme.

6.0 CONCLUSIONS

Following a careful analysis of the MHSU's care and treatment by LPT and a consideration of the evidence collected by the Leicestershire Murder Investigation Team, the IIT concludes that the attack on Ms V on 3 January 2007 was not specifically attributable to the MHSU's diagnosed mental health disorder or its management.

This appears to be a particularly unfortunate and tragic case. The evidence is that the delayed receipt of payment for his work as a contract cleaner was "the last straw" for the MHSU and that his general sense of frustration with life erupted into a sudden, unpredictable and violent rage. In his anger the MHSU randomly attacked Ms V who had the misfortune to be in the vicinity because simply going about her routine duties at her place of work.

The IIT concludes that the service the MHSU received from LPT was mostly of a good standard. In particular nothing has been identified that the mental health service could have done to either predict or prevent the event of 3 January 2007.

As with all investigations involving retrospective analysis, the IIT identified some aspects of the service provided to the MHSU and the interface communications between the various teams and agencies involved with him and his family that could have been improved.

These aspects were:

- The information provided to the LCCHTT by inpatient services and the MHSU's care coordinator at the time of his early discharge was inadequate. The team was not informed of the discharge plan or what was to happen after discharge from the LCCHTT service.
- On referral of the MHSU to the PIER team, information should have been given regarding the pre-admission risk issue of knife carrying for his personal safety. It was fortunate that the MHSU and his partner told the PIER team about this at the time of their first meeting on 27 October 2006.
- The discharge of the MHSU from the LCCHTT on 6 October 2006 represented unsafe practice. No MHSU should be discharged into a vacuum without awareness on the part of the nominated care coordinator of the discharge.
- CYPS should also have been notified of the MHSU's discharge from the LCCHTT on 6 October 2006 and of the delay in his assessment for PIER.
- It was good practice for PIER to provide CYPS with a report for the multi-agency family meeting. However it would have been more useful to CYPS if the report had detailed the factors leading to the

MHSU's admission to hospital and his identified risk behaviours at that time.

While the above might have been managed better it does not alter the final conclusion reached by the IIT. Even if all the above had been addressed, the evidence to hand indicates that the outcome on 3 January 2007 would have been the same.

7.0 RECOMMENDATIONS

Recommendations
The IIT has three recommendations for the specialist mental health service in Leicester and one recommendation for Children's and Young People's services in Leicester. All recommendations are locally focused and target the systems and processes that govern the standards of clinical care and the interface between general adult services and the specialist mental health teams.

Recommendation 1: LPT must review the interface between operational policies of teams operating within Adult Services.
LPT must ensure that at minimum the operational policies pertaining to:

- inpatient services;
- community mental health services;
- Leicester City and Leicester County crisis resolution and home treatment teams;
- assertive outreach; and
- PIER

are reviewed in a coordinated and controlled way so that the interface between each is properly understood. Ideally the interface aspects of the protocols, or separate interface protocols, must be agreed between each service.

It must be clear in operational policies who is responsible for a patient's care at any time, especially at the point of discharge or transfer across services/teams. Operational policies must also describe clearly the steps needed to discharge this responsibility. An example of this would be:

"Patient A is being discharged from the PIER team and referred to the CMHT. The PIER team will retain responsibility until such time as a discharge/transfer meeting has taken place and a joint visit has taken place. If steps less than this are taken, e.g. inter team professional level discussion, this must be stated clearly in the clinical record. Until such time as this has occurred the PIER team will retain responsibility."

LPT must also ensure a system is in place to prevent individual teams from making ad-hoc changes to operational policies, which could create the opportunity for confusion to arise and allow a lack of consistent practice between teams that may lead to failings in care delivery.

Clear guidelines also need to be in place to manage disagreements between teams.

Target audience: LPT's Chief Operating Officer, all service managers responsible for the teams listed above.

Recommendation 2: LPT should improve its early discharge planning
This investigation identified that it is not the expected practice for LPT's CHRT services to receive a copy of the discharge plan for a MHSU taken on for early discharge from inpatient services. Neither is it customary for CYPS to receive a copy of the discharge plan where there is known Adult Services and CYPS involvement within the same home.

CRHT services
If the provision of support at home by a CHRT service is an aspect of a discharge plan, it seems sensible to ensure that all parties to the plan have access to it. The CHRT service cannot be expected to meet the requisite quality standards unless provided with full and complete information when assuming the responsibility for the care of a MHSU. Consequently it is recommended with immediate effect that whenever a MHSU is accepted for early discharge then the CRHT service is provided with:

- a copy of, or access to, the discharge plan; and
- a copy of, or access to, the most up to date risk assessment.

Ref: "*Guidance statement on fidelity and best practice for crisis services*", DH, 2007.

In adopting this recommendation LPT may wish the CHRT services to adopt the practice model currently used by PIER, namely going to the pre-existing team base and photocopying all previous records deemed important to have on PIER's independent file.

Note: The principles highlighted in this targeted recommendation apply to all discharge planning activities. They are not unique to early discharges.

Children and Young People's Services (CYPS)
LPT needs to look at the guidance it provides to its staff regarding the provision of information to CYPS when both agencies are providing a service to the same family. The IIT appreciates that mental health practitioners will have anxieties about this and the rights of the individual MHSU. However the Local Safeguarding Children Board for Leicester, Leicestershire and Rutland has a clear statement of intent in its guidance entitled "*Practice guidance adult mental health and child protection*". The former Department for Children, Schools and Families also provided guidance on information sharing and recommended greater collaboration in working practices within and across agencies.

The need for collaborative working, particularly with respect to agencies working for the protection of vulnerable adults and children, must be addressed or at least referenced within all operational policies for LPT services.

LPT might also consider practical guidance on obtaining early consent from MHSUs for enabling effective and complete cross agency communication when necessary. In the immediate acute phase of mental illness this will not be appropriate and/or possible. However once a MHSU has been stabilised the discussion and formal obtaining of consent may be appropriate in many situations.

LPT must also ensure that professional staff working in Adult Services are fully conversant with the following publications:

- The Local Safeguarding Children Board's guidance on information sharing: *"Practice guidance adult mental health and child protection"* (2009).
- The Social Care Institute for Excellence publications, SCIE Guide 30: *"Think child, think parent, think family: a guide to parental mental health and child welfare"* (July 2009) and "*At a glance 9*: *Think child, think parent, think family"* (July 2009.
- The Department of Health's guidance: "Information *sharing and mental health"* (September 2009).

Ideally LPT will develop its own local policy documents relating to these issues that effectively distil key practice principles and provide clear and accessible guidance to frontline staff.

Timescales :

CRHT services: For immediate consideration and implementation.

CYPS: The issue should be tabled for consideration by both the Corporate Governance and Safety Committee and the Governance Committee for Adult Services by September 2010. The expected outcome of these discussions is a clear action and development plan that will enable LPT to meet local and national safeguarding standards of practice.

Target audience: LPT's Chief Operating Officer, Service Manager for the CRHT teams (city and county), Service Manager for Inpatient Services.

Recommendation 3: LPT must achieve clear standards for discharging service users from CRHT services

The IIT is aware that LPT is presently undertaking a complete overhaul of the way the CRHT service operates across Leicestershire with a view to rewriting operational policy. The IIT has provided constructive feedback to the CRHT Service Manager in relation to the draft operational policy (2010) document. It is recommended that this feedback be formally considered for acceptance and incorporation into the final operational policy. Should a decision be made against inclusion of the feedback in the revised policy it is important that LPT is able to justify and articulate its rationale for that decision to the East Midlands Strategic Health Authority.

In particular the revised CRHT operational policy should set out clearly the standards expected when MHSUs are discharged from the CRHT service. Historically no such standards have been determined and to date no such standards are included in the draft operational policy (2010) document.

The IIT expects the standards to encompass all of the following.

- When discharge becomes a consideration and the MHSU is on a CMHT caseload, there will always be a discharge CPA meeting or, at minimum, a face-to-face meeting with the MHSU's care coordinator.

- If a discharge CPA or face-to-face meeting is not possible, the reasons for this are clearly documented in the MHSU's clinical records.

- When a service user is discharged back to primary care services (i.e. there is no continuing mental health care from specialist mental health services), a formal discharge summary is faxed to the MHSU's GP within 5 working days of discharge. The faxed summary

will contain the same headings and content as a discharge letter from community or inpatient services. In the case of a planned discharge there should be no reason why this is not achievable.

Target audience: LPT's Chief Operating Officer, Service Manager for the CHRT teams (city and county).

Recommendation 4: For Leicester City Council's Children and Young People's Services (CYPS) need to consider producing a guidance note on core information it requires from other agencies in preparation for reports where professionals cannot attend for multi-agency meetings. For Leicester City Council's Children and Young People's Services
The IIT understands that CYPS is of the view that, when professionals and agencies from whom it would like to receive input reports are unable to attend for family support meetings or similar, it is unnecessary to provide them with outline guidance. CYPS believes that there is sufficient existing guidance provided by the policies and procedures of the Local Safeguarding Children Board supplemented by the guidance issued by the Department for Children, Schools and Families and the Social Care Institute for Excellence. However although safeguarding is very important it is not the only issue that mental health professionals have to address.

The IIT has reviewed the available safeguarding documents and guidance. It is of the view that it would be beneficial and require minimal effort for CYPS to produce a simple guidance note that specifically addresses the information that should be included in reports provided by mental health services and other agencies.

This guidance could be a simple list such as follows:

"In providing Children and Young People's Services with a report of the involvement of your services with Person A, it is helpful if you formulate the report under the following key headings:

- An overview of how Person A came to receive a service from you.
- An overview of current care and treatment.
- Any issues that impact upon child safety (risk of harm, neglect, alcohol or substance misuse, suicide risk etc, paranoid behaviours that may be frightening to a child etc).
- Any issues that may make a joint professionals' meeting useful to the effective care of the family."

Target Audience: Interim Divisional Director Social Care & Safeguarding, Children and Young People's Services

Timescale :

The SHA must be advised of the position of CYPS within three months of the publication of this report.

APPENDIX 1: DETAILED CHRONOLOGY OF CONTACTS BETWEEN THE MHSU AND LPT

Date	Event/chronology	Contextual information
07/09/06	First referral following threats of self harm	Partner reported that the MHSU would not talk to anyone. He believed that he was being watched and that cars were chasing him. She reported that he had taken an overdose a few days ago. There is no notation as to what in the crisis record. (Later in the records a figure of at least 50 ibuprofen is mentioned but it is unclear where this figure came from). The MHSU was reportedly not using alcohol or drugs at this time.
07/09/06	LCCHTT assessment	This assessment identified that the MHSU had thoughts of self harm and had recently started carrying a knife to protect him from what he perceived to be hostile neighbours on the housing estate.
07/09/06	Medical (SHO) assessment on admission	The medical history confirmed the information collected by LCCHTT. The MHSU was consistent in his history of taking ibuprofen for relief and not to harmfully overdose. The medical notes indicate the MHSU's experience in Uganda was talked about but that he became distressed and would not elaborate on this. It is noted that he reported having been to beatings and that some of his family were dead.
07/09/06	CPA assessment document completed	

Date	Event/chronology	Contextual information
08/09/06	SHO assessment	Background history was taken from the MHSU's partner. This was also consistent with information previously documented.
08/09/06 - 11/09/06		The nursing progress show that the MHSU was initially withdrawn and reluctant to eat or drink in spite of encouragement by staff. By 11 September he was noted to be more relaxed and had a conversation with staff.
11/09/06	SHO assessment	The MHSU was noted to be in better spirits. He was noted to be more talkative, but remained socially isolated. He was also concerned that fellows on ward "keep to themselves" and felt that others saw him differently. He is reported to have felt that someone was going to attack and strangle him. The notes say that MHSU was missing his girlfriend and baby but that his girlfriend called every day.

Date	Time	Event/chronology	Contextual information
12/09/06		Multidisciplinary team review (MDT)	The MDT review reveals more context about the MHSU. It was noted that he told staff that he had been tortured in Uganda; his father had been taken 4 years ago and the MHSU did not know if he was alive or not. He believed his mother was alive but was concerned about her. It was noted that he had a good relationship with his partner but that the culture and life was very different in England. He remained anxious.
14/09/06		SHO bleeped medical registrar because of the possibility of LVH revealed by an echo cardiogram (ECG)	The medical registrar provides reassurance that owing to his nationality and the MHSU's build (tall and thin) the ECG findings are unlikely to be a problem but for the ECG to be repeated to make sure of this.

Date	Event/chronology	Contextual information
15/09/06 - 17/09/06	Nil of note	There was a medical assessment on the 15th which was quite detailed. It notes that the MHSU was keen to spend time at home so a day's leave was agreed for the Saturday. The home visit would enable the MHSU to see how he felt being back at home. The SHO noted that he felt that the MHSU's partner put pressure on him but that he (the MHSU) said he is used to her and that "all women lose their temper". **Comment:** It is this information that should have been relayed to Children and Young People's Services. Although they already knew that the MHSU's partner could be domineering it would have been good practice to inform them as the mental health service did not know that social services were aware.
16/09/06	The home leave day	The MHSU returned to ward as planned with no problems reported.

Date	Event/chronology	Contextual information
18/09/06	Information sought from partner	The MHSU's partner reported that he was much better but still depressed at times. She reported that he spent most of the day caring for their baby, and was reluctant to leave him and didn't want to come back to hospital. He, she said, wanted to go to London to look for his family. However, she advised that he come back to hospital as planned.
19/09/06	MDT review	Because of the MHSU's strong desire to go home early, discharge was agreed with crisis team support.
19/09/06	The discharge plan	There was a plan for referral to PIER for the MHSU's ongoing management if PIER agreed to accept him on to its caseload. It is noted in the records that if there was a waiting list for PIER then the MHSU was to be picked up by CMHT in the interim period.
20/09/06	LCCHTT assessment	Assessed for early discharge, on the day of discharge, and taken on by LCCHTT. (Note: the LCCHTT had assessed the MHSU pre-admission on 7 September).

Date	Event/chronology	Contextual information
21/09/06 - 29/09/06	Initially daily visits, then every other day, interspersed by telephone contact	The MHSU was noted to be appearing quite well but some paranoia remained. It is noted that he had recommenced a part-time job. The records note there was evidence of him bonding with his son. The records also note that staff had some residual concerns regarding the other children of the MHSU's partner. The notes evidence that staff did try and ask her about her previous children but for a variety of reasons (4 year old's bed time and a guest present) they were unable to do this successfully. Consequently Social Services were contacted and the key worker for the children identified. LCCHTT planned to attend a joint family meeting with Social Services on 2 October 2006. This meeting was subsequently cancelled.
21/09/06	Letter from PIER team to the MHSU's consultant psychiatrist	This advised of a waiting list of 4-6 weeks for the commencement of the assessment process and that an interim assessment would be undertaken during this time for screening purposes to ensure that the MHSU was suitable for the PIER caseload. The correspondence recommended referring the MHSU to the appropriate CMHT if follow up was needed in the interim.

Date	Event/chronology	Contextual information
02/10/06	Family meeting cancelled by social services	The MHP continued to try and meet with the MHSU but there was no answer at his home (phone call).
03/10/06	Home visit by LCCHTT	The MHSU was informed of his discharge from LCCHTT at this time and given a two week medication prescription.
05/10/06	Discharge letter to GP	The discharge letter was written from LCCHTT to the MHSU's GP.
27/10/06	PIER CPA assessment	The MHSU expressed that he needed to talk about his experiences in Uganda. He was noted to be willing to engage with PIER and wanted treatment. The progress notes say that the MHSU had stopped taking his medication because he didn't think he needed it. It is also noted that the home visit was terminated early because the MHSU was preoccupied with his family, especially the children.
31/10/06	Telephone contact	The PIER team tried to arrange a further appointment with the MHSU. He advised he was not available until 6 November. Because of the PIER MHP's annual leave arrangements an appointment was made for 13 November.

Date	Event/chronology	Contextual information
16/11/06	PIER reviewed the risk assessment and risk management plan	The PIER MHP clearly stated what might trigger or indicate a relapse for the MHSU and also detailed who should be contacted in a crisis.
13/11/06	Attempted home visit	This was a planned home visit. The MHSU was not at home. A further appointment was offered for 27 November 2006.
15/11/06	PIER MDT review	The MHSU was discussed as the team had had limited contact with him. The outcome of this was that a further period of assessment was agreed as necessary. It was also agreed that PIER 1 (care coordinator) would liaise with the MHSU's consultant psychiatrist and keep her informed. The plan was also to contact the MHSU's GP to see if he had details of any previous psychiatric treatment for the MHSU. PIER 1 was also to investigate any known safeguarding issues.
17/11/06	Telephone contact attempted	There was no answer so a message was left for the MHSU regarding his appointment.

Date	Event/chronology	Contextual information
20/11/06	Telephone contact attempted	A further attempt was made at contacting the MHSU - again this was unsuccessful and a message was left for him to contact the team.
20/11/06	The CMHT contacted PIER for an update	PIER had no new information for the CMHT.
20/11/06	The MHSU's consultant psychiatrist contacted PIER for an update	As a result of the challenges in making contact with the MHSU, his consultant psychiatrist suggested contacting the children's social worker as she might know where the MHSU and/or his partner were. He might, she suggested, have gone to London. The MHSU's consultant psychiatrist made clear her wish to be kept informed about the MHSU.
22/11/06	Telephone contact with the MHSU	The MHSU told the PIER professional (not PIER 1 but her colleague) that he had been busy and that he was looking after his child. His partner is noted to have come to the phone and advised that the MHSU had not been taking his medication but that he had got more olanzapine via his GP and was taking it again. However, she also told the PIER professional that the dosage had been reduced to 2.5mg due to side effects (previously it had been 5mg). The PIER professional told the MHSU that he should continue with his olanzapine at the dosage prescribed by his consultant psychiatrist and that she would visit on 27 November.

Date	Event/chronology	Contextual information
23/11/06	Telephone contact between PIER and the MHSU's GP	PIER 1 rang the GP to try and get some further information. However she was informed that the MHSU had only been registered with the practice since September 2006. The GP surgery suggested that she contact patient registrations to see where he had previously been registered.
24/11/06	Home visit planned for 27 November took place	The MHSU appeared to have lost weight, and looked tired and pale. He said he had not been eating. He also said he was taking his olanzapine 5mg daily. PIER 1 continued her assessment - she explored the circumstances of the MHSU's initial hospital admission. The MHSU talked about "the voices" but said they were his own thoughts about himself. He also described his partner as controlling and that he would like to leave her but he was concerned for the welfare of his son. The MHSU continued to await the outcome of his appeal regarding his asylum status, he still felt that people talked about him when he went outside. He also told PIER 1 that he felt anxious when he was outside and preferred to stay indoors. The plan was for medical review on 4 December following which a decision was to be made regarding his suitability for PIER. PIER 1 was to be the MHSU's care coordinator.

Date	Event/chronology	Contextual information
04/12/06	Assessed by staff grade psychiatrist	PIER 1, the care coordinator, was present. The MHSU's partner was present and their son. The assessment record noted that "since admission things haven't been the same". The MHSU was noted to feel that people in the estate had changed their attitudes towards him. (It does not say how or why). The registrar noted in his record that the MHSU was suffering from overvalued ideas, or delusions. The record of the assessment is thorough.
06/12/06	PIER MDT review	As a result of the assessment by the staff grade, the challenges of effective assessment and the lack of certainty regarding diagnosis, the MHSU was taken on to the PIER caseload for an extended period of assessment.

Date	Event/chronology	Contextual information
08/12/06	Telephone call to PIER 1	The call was received from the Childcare support worker Asking if PIER 1 could attend at the family support meeting on the 12 December.
11/12/06	Fax sent to SS by PIER 1	Because she could not attend the planned family meeting PIER 1 wrote a report for CYPS. She also attempted to contact the MHSU on this day but there was no answer.
18/12/06	The MHSU did not attend his outpatient appointment	The clinical record notes that the care coordinator would be seeing the MHSU during the week.
18/12/06	Attempted home visit	PIER 1 visited the MHSU. He wasn't there but his partner was. The MHSU, PIER 1 was informed, was out working as a cleaner. A new appointment time was given to the MHSU's partner for him. His partner is reported to have told PIER 1 that the MHSU was OK and taking his prescribed medication.

Date	Event/chronology	Contextual information
19/12/06	Correspondence to the MHSU	A letter confirming the new appointment for 28 December was sent to the MHSU from PIER 1.
20/12/06	Social services contacted PIER	Social Services was advised that the MHSU had not attended his outpatient appointment. Social services advised PIER 1 that the next family support meeting was on 30 Jan 2007.
28/12/06	Home visit by PIER 1	The MHSU was at home with his partner and children. He appeared in good spirits and told PIER 1 that he had put on weight. He advised that he was well but stressed out regarding his asylum appeal. He reported that it was always on his mind and left him feeling confused. PIER 1 asked him about his background. He is noted to have told PIER 1 that his father was a general in the army and was murdered for political reasons. This he said caused his family to splinter and he fled to the UK. The MHSU reported having “terrible memories that caused him pain”. He also spoke about his cultural isolation. No evidence of psychosis was observed at this visit. His mental state was noted to be stable. The next visit was agreed for 5 January 2007.

Date	Event/chronology	Contextual information
28/12/06	Telephone: PIER had completed a clinical risk management summary sheet	This identified a primary risk of self harm. A potential child protection risk was present due to a lack of parenting skills rather than any violence or direct harm concerns. The assessment states that he had not voiced any plan/intent to harm himself or others. The risk assessment did not notate previous behaviour of carrying a knife “to protect self”.
02/01/07	Care plan	Plan reasonably detailed. It identified the need for opportunities for MHSU to interact socially with others from his country.
03/01/07	Telephone call received re. incident	
05/01/07	Letter to the MHSU’s partner offering support	

APPENDIX 2: INVESTIGATION METHODOLOGY

The investigation methodology was structured and embraced the key phases detailed in the National Patient Safety Agency's e-learning toolkit. Key activities were:

- Critical appraisal of the MHSU's clinical records and the identification of areas that the IIT needed to explore.
- Document analysis.
- Face-to-face interviews and discussions with staff working in LPT, social services and the police.

The investigation tools utilised were:

- Structured timelining.
- Triangulation and validation map.
- Investigative interviewing.
- Affinity mapping and qualitative content analysis.

The primary sources of information used to underpin the findings of this investigation were:

- Leicestershire Constabulary's investigation records.
- The MHSU's mental health records.
- LPT's internal investigation documents.
- Interviews with:
  - the MHSU's consultant psychiatrist;
  - representatives of LPT's LCCHTT service;
  - professionals from the PIER service, including PIER 1 and her line manager; and
  - Social Services staff from LCC working in Children and Young People's Services.
- A face to face meeting with the partner of the MHSU.
- A review of the operational policy for the CMHT.
- A review of the CMHT operational policy.
- A review of the inpatient operational policy.

APPENDIX 3 : GLOSSARY

The Care Programme Approach (CPA)[5]

CPA is the framework for good practice in the delivery of mental health services. In early 2008 the *"Refocusing the Care Programme Approach Policy and Positive Practice"* document was published[6]. This made changes to the existing Care Programme Approach.

One of the key changes is that CPA no longer applies to everyone who is referred to and accepted by specialist mental health and social care services. However, its principles and values do. CPA still aims to ensure that services will work closely together to meet identified needs and provide support to MHSUs in recovery. If a MHSU has a number of needs, and input or support from a range of people or agencies is necessary, then the formal CPA framework will apply. When the needs have been identified and agreed, a plan for how to meet them will be drawn up and a care coordinator will be appointed. The MHSU and his/her views will be central throughout the care and recovery process.

There are four elements to the Care Programme Approach:

- ❒ Assessment – this is how the MHSU's health and social care needs are identified.
- ❒ Care coordinator – someone is appointed to oversee the production and delivery of a MHSU's care plan, keep in contact, and ensure good communication between all those involved in care.
- ❒ Care plan – a plan will be drawn up which clearly identifies the needs and expected outcomes, what to do should a crisis arise and who will be responsible for each aspect of the care and support.
- ❒ Evaluation and review – the care plan will be regularly reviewed with the MHSU to ensure that the intended outcomes are being achieved and if not that any necessary changes are made.

The (new) CPA will function at one level and what is provided is not significantly different to what has been known previously as "enhanced CPA".

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[5] http://www.mentalhealthleeds.info/infobank/mental-health-guide/care-programme-approach.php

[6] http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_083649.pdf

Risk assessment
Risk assessment and risk management should be part of the routine care provided to a MHSU. At present there is great local variability in the practice of risk assessment and in the documentation tools used. However the general principles of risk assessment and risk management rely on undertaking an assessment and identifying aspects of an individual's behaviour and lifestyle that might pose a risk to self, or to others, and to the qualification of that risk where possible. Once risks are identified it is the role of the assessing professional to judge the magnitude of the risk and to devise a plan aimed at reducing or removing the risk.

Crisis resolution and home treatment
The Mental Health National Service Framework (NSF) and the NHS Plan, published by the Department of Health (DH) in 1999 and 2000 respectively, made it national policy for mental health services to develop crisis services. On the basis of population calculations, a target was set to establish 335 new crisis resolution and home treatment teams across England by December 2004, with those teams having served 100,000 people by December 2005.

What does a crisis resolution home treatment team do?
A crisis resolution home treatment team aims to provide treatment and care to someone with an acute mental health problem in the least restrictive environment. This is provided in two separate ways.

Crisis resolution
This is a community-based team providing rapid access for assessment of someone thought to be experiencing a mental health crisis. Following assessment the team will stay involved until the identified care needs have been resolved.

A crisis is considered to be when a service user’s normal methods of coping are not working, resulting in a rapid deterioration in their mental health that results in a need for psychiatric professional involvement.

Home treatment
This service provides time limited intensive home support for a period of approximately six weeks in addition to the care that a service user may already be receiving, e.g. from a care coordinator/key worker. Home treatment involves assessment, care planning and interventions specific to meeting a service user's needs with the aim of preventing the need for an in-patient stay. If a service user is already an in-patient, the crisis team will work with the individual to try to ensure an early discharge and to provide support when the service user leaves hospital.

Early intervention services for people with psychosis
An early intervention team serves young people with early psychosis who are aged 14–35 and their families. The programme bridges youth and adult mental health services, and links community care with hospital services.

Early intervention teams have been set up all across the country as part of the National Service Framework for Mental Health. Their primary aim is to improve the life chances of those affected by psychosis, and include raising awareness of what psychosis is and how it can affect people, to challenge stigma and promote social inclusion.

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"*At a glance 9: Think child, think parent, think family"* (Social Care Institute for Excellence, 2009)

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