HASCAS
Health and Social Care Advisory Service

Independent Investigation

into the

Care and Treatment Provided to Mr. Y

by the

Sussex Partnership NHS Foundation Trust

Commissioned by
NHS South of England, South East Coast
Strategic Health Authority

Report Prepared by HASCAS Health and Social Care Advisory Service
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Contents

1. Investigation Team Preface

The Independent Investigation into the care and treatment of Mr. Y was commissioned by NHS South of England (South East Coast) Strategic Health Authority pursuant to *HSG (94)27*.[1] The Investigation was asked to examine a set of circumstances associated with the deaths of Mr. and Mrs. Y who died on 23 December 2007. The Investigation examines the care and treatment Mr. Y received from the Sussex Partnership NHS Foundation Trust between 26 November and 6 December 2007, but does not examine that provided by The Priory Hospital between 6 and 23 December 2007 as this falls outside of the scope of HSG (94) 27. It should be noted that Mr. Y was no longer a patient with the Sussex Partnership NHS Foundation Trust at the time of his death, and that of Mrs. Y, having been discharged at his request to The Priory three weeks before.

On 5 November 2008 HM Coroner recorded a verdict of *"unlawful killing"* with respect to Mrs. Y's death and a narrative verdict with respect to Mr. Y's death.

Investigations of this sort should aim to increase public confidence in statutory mental health service providers and to promote professional competence. The purpose of the Investigation is to learn any lessons that might help to prevent any further incidents of this nature and to help to improve the reporting and investigation of similar serious events in the future.

Those who attended for interview to provide evidence were asked to give an account of their roles and provide information about clinical and managerial practice. They all did so in accordance with expectations. We are grateful to all those who gave evidence directly, and those who have supported them. We would also like to thank the Trust's Senior Management Team who granted access to facilities and individuals throughout this process. The Trust's Senior Management Team has acted at all times in an exceptionally professional manner during the course of this Investigation and has engaged fully with the root cause analysis ethos of this work.

1. Health Service Guidance (94) 27

2. Condolences to the Family and Friends of Mr. and Mrs. Y

The Independent Investigation Team would like to extend their condolences to the family and friends of Mr. and Mrs. Y. At the time of writing this report the family did not wish to take part in the Investigation process.

3. Incident Description and Consequences

Background for Mr. Y (deceased)

On 26 November 2007 Mr. Y was taken to the Accident and Emergency department of St Richard's General Hospital, Chichester. It was reported that Mr. Y and his wife had been experiencing marital difficulties for some time. Mr. Y was preoccupied with thoughts of whether his wife was a virgin when they married 46 years previously. His wife had disclosed that day, for the first time, that she was not. On this day Mr. Y left the house to play golf. He returned at around 09.30 hours knowing that his wife was out. He took between five and seven 7.5mg Zopiclone tablets and took a pipe and connected this to the exhaust of his car and switched on the engine. He later reported that he could see the fumes but nothing happened. He then took a canister of gas which he took into the car and opened the outlet valve once he had enclosed himself within the vehicle. Mr. Y had left a letter for his wife and family. He was found by his daughter and wife at around 12.30 hours. He was reported to be very drowsy and confused when he was found.[2] He was admitted to the Harold Kidd Unit, Chichester, which is part of the Sussex Partnership NHS Foundation Trust.

By 29 November 2007 Mr. Y claimed that he was no longer suicidal and both he and his family commenced discussions about him being transferred to The Priory, an independent sector service. At this time the family became concerned that he was stating his intention to kill his wife and these concerns were communicated to his Consultant Psychiatrist (Consultant Psychiatrist 1) at the Harold Kidd Unit. The transfer process to The Priory was halted and Mr. Y was kept on the unit with his consent as an informal patient and where he was assessed on a daily basis. His mental state appeared to improve.

On 6 December 2007 Mr. Y was transferred to The Priory as an informal inpatient. Mr. Y appeared to continue with his progress and weekend leave was arranged on 13 December. Following consultation with Mr. Y and his wife on 17 December (the Monday following his weekend leave) he was discharged from The Priory.

Incident Description and Consequences

Mr. Y killed himself in a car accident which took place on 23 December 2007, he died later in hospital on 24 December 2007. When the Police went to the family home to notify Mrs. Y of the accident they found her slumped on the floor dead. She had suffered from multiple stab wounds and blunt trauma injuries. The police treated the deaths as a case of homicide/suicide.

HM Coroner Penelope Schofield said *"…[Mr. Y] died on the 24 December 2007 having attempted to take his own life whilst driving a motor vehicle on 23 December 2007 whilst suffering from a disturbed mind having been discharged as a voluntary patient of The Priory Hospital Hove on 17 December 2007 but remaining under their care as an outpatient."*

2 Clinical notes V1 pp 52 & 55

The Coroner found that Mrs. Y had been unlawfully killed and that the Police confirmed there was no evidence to suggest any third parties were involved.

4. Background and Context to the Investigation (Purpose of Report)

The Health and Social Care Advisory Service was commissioned by NHS South of England, South East Coast (the Strategic Health Authority) to conduct this Investigation under the auspices of Department of Health Guidance *EL(94)27, LASSL(94) 4*, issued in 1994 to all commissioners and providers of mental health services. In discussing 'when things go wrong' the guidance states:

"…in cases of homicide, it will always be necessary to hold an inquiry which is independent of the providers involved".

This guidance, and its subsequent 2005 amendments, includes the following criteria for an independent investigation of this kind:

i) When a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.

ii) When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate level.

iii) Where the SHA determines that an adverse event warrants independent investigation. For example if there is concern that an event may represent significant systematic failure, such as a cluster of suicides.

The purpose of an Independent Investigation is to thoroughly review the care and treatment received by the patient in order to establish the lessons to be learnt, to minimise the possibility of a reoccurrence of similar events, and to make recommendations for the delivery of Health Services in the future, incorporating what can be learnt from a robust analysis of the individual case.

The role of the Independent Investigation Team is to gain a full picture of what was known, or should have been known, at the time by the relevant clinical professionals and others in a position of responsibility working within the Trust and associated agencies, and to form a view of the practice and decisions made at that time and with that knowledge. It would be wrong for the Investigation Team to form a view of what should have happened based on hindsight, and the Investigation Team has tried throughout this report to base its findings on the information available to relevant individuals and organisations at the time of the incident.

The process is intended to be a positive one, serving the needs of those individuals using services, those responsible for the development of services, and the interest of the wider public. This case has been investigated fully by an impartial and independent investigation team.

5. Terms of Reference

The Terms of Reference for this Investigation were set by NHS South of England (South East Coast) Strategic Health Authority. Due to the passage of time that had elapsed between the time of the incident and the time of the commissioning of the Independent Investigation it was agreed that the case would be managed as a desk top review instead of as a full panel, wide-ranging process. The Terms of Reference were as follows:

"The independent inquiry is commissioned by NHS South East Coast. It is commissioned in accordance with guidance published by the Department of Health in HSG (94)27 The Discharge of Mentally Disordered People and their Continuing Care in the Community and the updated paragraphs 33 – 36 issued in June 2005.

Terms of reference

1. To examine the care and treatment of Mr. Y, in particular:

- *The history and extent of his involvement with health and social care services.*
- *The suitability of his treatment, care and supervision in respect of:*
  - *Clinical diagnosis*
  - *Assessed health and social care needs*
  - *Assessed risk of potential harm to self and others*
  - *Any previous psychiatric history*
  - *Any previous forensic history*

- *The assessment of the needs of carers and his family.*
- *The extent to which Mr. Y complied with his prescribed care plans.*
- *The extent to which Mr. Y's care and treatment corresponded to statutory obligations, the Mental Health Act 1983, and other relevant guidance from the Department of Health.*
- *The quality of Mr.Y's treatment, care and supervision, in particular the extent to which his prescribed care plans were:*
  - *Appropriate*
  - *Effectively delivered*
  - *Monitored by the relevant agency.*
- *The adequacy of the framework of operational policies and procedures applicable to the care and treatment of Mr. Y and whether staff complied with them.*
- *The competencies of staff involved in the care and treatment of Mr. Y and the adequacy of the supervision provided for them.*
- *The internal investigation completed by Sussex Partnership NHS Foundation Trust and the actions that arose from this.*
- *The Trust clinical governance and assurance systems as they relate to care and treatment provided to Mr. Y, this in particular regard to:*
  - *Audit*

- *Clinical supervision*
- *Clinical leadership*

- *Any other matters that the investigation team considers arise out of, or are connected with, the matters above.*

2. To examine the adequacy of the collaboration and communication between all the agencies involved in the care and treatment of Mr. Y, or in the provision of services to him, including Sussex Partnership NHS Foundation Trust and relevant agencies and GP services.

3. To prepare a written report that includes recommendations to the strategic health authority so that, as far as is possible in similar circumstances in the future, harm to the public, patients and staff is avoided.

Approach

The investigation team will conduct its work in private and be expected to take as its starting point the Trust's internal investigation supplemented, as necessary, by access to source documents and interviews, as determined by the team. The team is encouraged to engage relatives of Mr. Y and his wife and any relevant staff in the inquiry process.

The team will follow good practice in the conduct of interviews by, for example, offering the opportunity for interviewees to be accompanied and giving them the opportunity to comment on the factual accuracy of their interview transcript.

Timetable

The precise timetable will be dependent on a number of factors including the availability of Mr. Y's clinical records, the investigation team's own assessment of the need for information and the number of interviews necessary. The team is asked to have completed the inquiry, or a substantial part of it, within six months of starting its work. Monthly reports on progress should be provided to NHS South East Coast.

Publication

The outcome of the investigation will be made public. The nature and form of publication will be determined by NHS South East Coast. The decision on publication will take account of the views of the relatives and other interested parties."

It should be noted that at the time of his death, and of the killing of his wife, Mr. Y was no longer a patient with the Sussex Partnership NHS Foundation Trust having transferred his care and treatment to The Priory. The powers of *EL(94)27, LASSL(94) 4* were not thought by NHS commissioners to extend to the independent sector in cases where the service user has commissioned their own care and treatment under private funding arrangements. For this reason no Investigation has been conducted into the care and Treatment provided by The Priory which is an independent sector provision and which was not funded by any NHS contribution.

6. The Independent Investigation Team

Selection of the Investigation Team

The Investigation Team was comprised of individuals who worked independently of the Sussex Partnership NHS Foundation Trust. All professional team members retained their professional registration status at the time of the Investigation, were current in relation to their practice, and experienced in Investigation and Inquiry work of this nature. The individuals who worked on this case are listed below.

Independent Investigation Team Leader

Dr. Androulla Johnstone	Chief Executive, Health and Social Care Advisory Service. Chair, Nurse Member and Report Author

Investigation Team Members

Dr. David Somekh	HASCAS Health and Social Care Advisory Service Associate and Consultant Psychiatrist Member of the Team
Dr. Len Rowland	Director of Research and Development, HASCAS Health and Social Care Advisory Service and Clinical Psychologist Member of the Team

Support to the Investigation Team

Mr. Christopher Welton	Investigation Manager, Health and Social Care Advisory Service
Mrs. Fiona Shipley	Stenography services

Independent Advice to the Investigation Team

Mr. Ashley Irons	Solicitor, Capsticks

7. Investigation Method

In February 2012 NHS South of England, South East Coast (the Strategic Health Authority) commissioned the Health and Social Care Advisory Service (HASCAS) to conduct this Independent Investigation under the Terms of Reference set out in section five of this report. The Investigation Methodology is set out below. It was the decision of the Strategic Health Authority that full anonymity be given to Mr. and Mrs. Y and all witnesses to this Investigation.

Communications with the Family of Mr. and Mrs. Y

The commissioner of this Investigation made contact with the family of Mr. and Mrs. Y in Janaury 2014. The family did not wish to take part in the Investigation process.

Communications with the Sussex Partnership NHS Foundation Trust

The SHA made contact with the Sussex Partnership NHS Foundation Trust in August 2012. This communication served to notify the Trust that an Independent Investigation under the auspices of *HSG (94) 27* had been commissioned to examine the care and treatment of Mr. Y. A formal meeting was held between the Investigation Team Leader and the Trust in December 2012 once the clinical records had been released and the Investigation process commenced.

The Independent Investigation Team worked with the Trust liaison person to ensure:

- all clinical records were identified and dispatched appropriately;
- each witness received their interview letter and guidance in accordance with national best practice guidance;
- that each witness was supported in the preparation of statements;
- that each witness could be accompanied by an appropriate support person when interviewed if they so wished;
- that a workshop for witnesses to the Independent Investigation was held on 22 January 2013. The aim of the workshop was to ensure that witnesses understood the process, were supported and could contribute as effectively as possible;
- that interviews on 4, 5 and 6 February 2013 were held at the Trust Headquarters in Worthing, West Sussex. The Investigation Team were afforded the opportunity to interview witnesses and meet with the Senior Managers of the Trust.

Factual accuracy and headline findings communications were held between the Independent Investigation Team and the Sussex Partnership NHS Foundation Trust in accordance with Investigation best practice.

The draft report was sent to the Trust for factual accuracy checking in March 2014. Relevant clinical witnesses were also sent key sections of the report for factual accuracy checking. Throughout the Investigation process communications were maintained on a regular basis and took place in the form of telephone conversations and email correspondence.

Witnesses Called by the Independent Investigation Team

Each witness called by the Investigation was invited to attend a briefing workshop. Each witness also received an Investigation briefing pack. The Investigation was managed in line with Salmon compliant processes.

Even though this Investigation was commissioned as a desk top review the decision was taken to interview the following individuals in order to ensure fairness and transparency. The Consultant Psychiatrist who led Mr. Y's care and treatment could not be interviewed due to ill health.

Table One
Witnesses Interviewed by the Independent Investigation Team

Date	Witnesses	Interviewers
4 February 2013	Trust Director of Nursing and Quality Trust Director of Governance *** Service Director, West Sussex Care Division *** Interim Clinical Director, Older Peoples Mental Health *** Internal Investigation Reviewers *** Ward Manager Harold Kidd Unit (at the time of the incident)	Investigation Team Nurse/Leader Investigation Team Psychiatrist Investigation Team Psychologist In attendance: Stenographer

Investigation Procedures

The Independent Investigation Team adopted Salmon compliant procedures during the course of its work. These are set out below:

1. Every witness of fact will receive a letter in advance of appearing to give evidence informing him or her:

(a) of the terms of reference and the procedure adopted by the Investigation; and

(b) of the areas and matters to be covered with them; and

(c) requesting them to provide written statements to form the basis of their evidence to the Investigation; and

(d) that when they give oral evidence, they may raise any matter they wish, and which they feel may be relevant to the Investigation; and

(e) that they may bring with them a work colleague, member of a trade union, lawyer or member of a defence organisation to accompany them with the exception of another Investigation witness; and

(f) that it is the witness who will be asked questions and who will be expected to answer; and

(g) that their evidence will be recorded and a copy sent to them afterwards to sign; and

(h) that they will be given the opportunity to review clinical records prior to and during the interview;

2. Witnesses of fact will be asked to affirm that their evidence is true.

3. Any points of potential criticism will be put to a witness of fact, either orally when they first give evidence or in writing at a later time, and they will be given full opportunity to respond.

4. Any other interested parties who feel that they may have something useful to contribute to the Investigation may make written submissions for the Investigation's consideration.

5. All sittings of the Investigation will be held in private.

6. The findings of the Investigation and any recommendations will be made public.

7. The evidence which is submitted to the Investigation either orally or in writing will not be made public by the Investigation, save as is disclosed within the body of the Investigation's final report.

8. Findings of fact will be made on the basis of evidence received by the Investigation.

9. These findings will be based on the comments within the narrative of the Report.

10. Any recommendations that are made will be based on these findings and conclusions drawn from all the evidence.

Independent Investigation Team Meetings and Communication

The Independent Investigation Team Members were recruited following a detailed examination of the case. This examination included analysing the clinical records and reflecting upon the Investigation Terms of Reference. Once the specific requirements of the Investigation were understood the Team was recruited to provide the level of experience that was needed. During the Investigation the Team worked both in a 'virtual manner' and together in face-to-face discussions.

Prior to the first meeting taking place each Team Member received a paginated set of clinical records, a set of clinical policies and procedures, and the Investigation Terms of Reference. It was possible for each Team Member to identify potential clinical witnesses and general questions that needed to be asked at this stage. Each witness was aware in advance of their interview of the general questions that they could expect to be asked.

The Team Met on the Following Occasions:

First Team Meeting 15 January 2013

The Investigation Team examined and discussed the chronological timeline which had been produced following the receipt of the full clinical records. The Investigation Team decided which staff they wished to interview and agreed questions they would ask. The list of documents required was made; this consisted of various Trust Policies and Operational Policies together with information about the Trust.

Second Team Meetings 4-6 February 2013

There was opportunity during the interview schedule which allowed the Investigation Team to consider the evidence collected from the interviews and also to comment on additional policies and relevant information regarding the organisation and systems of the team that had contact with Mr. Y and also management and governance issues.

Following the witness interviews the Team received the transcriptions and were able to add to the chronological timeline to reflect upon the additional information. There were also additional policies and procedures sent from the Trust which were examined. The Investigation Team was able to work in a virtual manner in order to complete the Root Cause Analysis methodology and develop the report findings and conclusions.

Other Meetings and Communications

The Independent Investigation Team Leader maintained communications on a regular basis with NHS South of England, South East Coast, throughout the process. Communications were maintained inbetween meetings by email, letter and telephone.

Root Cause Analysis

The analysis of the evidence was undertaken using Root Cause Analysis (RCA) Methodology. Root causes are specific underlying causes that on detailed analysis are considered to have contributed to a critical incident occurring. This methodology is the

process advocated by the National Patient Safety Agency (NPSA) when investigating critical incidents within the National Health Service.

The ethos of RCA is to provide a robust model that focuses upon underlying cause and effect processes. This is an attempt to move away from a culture of blame that has often assigned culpability to individual practitioners without due consideration of contextual organisational systems failure. The main objective of RCA is to provide recommendations so that lessons can be learnt to prevent similar incidents from happening in the same way again. However it must be noted that where there is evidence of individual practitioner culpability based on findings of fact, RCA does not seek to avoid assigning the appropriate responsibility.

RCA is a four-stage process. This process is as follows:

1. **Data collection.** This is an essential stage as without data an event cannot be analysed. This stage incorporates documentary analysis, witness statement collection and witness interviews. A first draft timeline is constructed.
2. **Causal Factor Charting.** This is the process whereby an Investigation begins to process the data that has been collected. A second draft timeline is produced and a sequence of events is established (please see Appendix One). From this causal factors or critical issues can be identified.
3. **Root Cause Identification.** The NPSA advocates the use of a variety of tools in order to understand the underlying reasons behind causal factors. This Investigation utilised the 'Decision Tree', the 'Five Whys' and the 'Fish Bone'.
4. **Recommendations.** This is the stage where recommendations are identified for the prevention of any similar critical incident occurring again.

When conducting a RCA the Investigation Team seeks to avoid generalisations and uses findings of fact only. It should also be noted that it is not practical or reasonable to search indefinitely for root causes, and it has to be acknowledged that this, as with all processes, has its limitations.

8. Information and Evidence Gathered (Documents)

The following documents were used by the Independent Investigation Team to collect evidence and to formulate conclusions.

1. Trust clinical records for Mr. Y.
2. Trust Internal Investigation Report and Investigation Archive.
3. Internal Investigation by The priory Hospital, Brighton and Hove.
4. Trust assurance and governance documentation.
5. Secondary literature review of media documentation reporting the death of Mr. Y.
6. Independent Investigation Witness Transcriptions.
7. Independent Investigation Witness statements.
8. Trust Clinical Risk Clinical Policies, past and present.
9. Trust Care programme Approach Policies, past and present.
10. Trust Incident Reporting Policies.
11. Trust Being Open Policy.
12. Trust Operational Policies.
13. Healthcare Commission/Care Quality Commission Reports for Sussex Partnership NHS Foundation Trust services.
14. Memorandum of Understanding *Investigating Patient Safety Incidents Involving Unexpected Death or Serious Harm:* a protocol for liaison and effective communication between the National Health Service, Association of Chief Police Officers and the Health and Safety Executive (2006).
15. Guidelines for the NHS: National Patient Safety Agency, Safer practice Notice, 10, *Being Open When Patients are Harmed* (September 2005).

9. Profile of the Sussex Partnership NHS Trust

The Sussex Partnership NHS Trust was formed in 2006 and became a Foundation Trust in August 2008; it has a turnover of £240 million. The Trust currently serves a population of 1.5 million people, employs 5,000 staff and provides services from 120 sites in Hampshire, Kent, London, Surrey, East Sussex and West Sussex. During 2012/2013 the Trust made 100,000 clinical contacts with service users.

The Trust Vision

1. *"Our vision is to ensure that the people who use our services, their carers and staff have the best possible experience of receiving help or working within our services*
2. *We are one of the largest mental health, learning disability and substance misuse trusts in the country*
3. *Our 5,000 staff provide treatment at home, in clinics, centres and hospitals across Sussex and beyond"*

The Five Strategic Aims

1. *"High quality clinical care for all people using Sussex Partnership services*
2. *Employer of enabled, engaged, well trained and motivated staff*
3. *A leading teaching and research mental health trust*
4. *A well-governed sustainable organisation*
5. *A growing organisation that invests in improving services"*

Services Provided

1. *"Primary mental health and wellbeing services including partnerships with GPs*
2. *Adult community mental health services for all adults over 18 (no upper age limit)*
3. *Specialist mental health services including eating disorders, personality disorders, and recovery services*
4. *Adult crisis and inpatient services*
5. *Dementia and later life services*
6. *Children and young people's services*
7. *Secure and forensic services*
8. *Substance misuse services*
9. *Prison healthcare services to HMP Lewes and HMP Ford."*

10. Chronology of Events

This Forms Part of the RCA First Stage

The chronology of events forms part of the Root Cause Analysis first stage. The purpose of the chronology is to set out the key events that led up to the incident occurring. It also gives a greater understanding of some of the external factors that may have impacted upon the life of Mr. Y his care and treatment from mental health services.

10.1. Chronology: Sussex Partnership NHS Foundation Trust

Mr. Y was born on **26 March 1941**. He was a retired property developer who at the time of his death, and that of his wife, had been married for 46 years.

Mr. Y was seen on three or four occasions by a private psychiatrist in **1999**. He was prescribed the anti-depressant Fluoxetine at that time and remained on this for the next nine years. His wife reported that when attempts were made to phase out the anti-depressant his mood deteriorated.[3]

On **26 November 2007** Mr. Y was taken to the Accident and Emergency department of St Richard's General Hospital, Chichester. It was reported Mr. Y and his wife had been experiencing marital difficulties for some time. Mr. Y was preoccupied with thoughts of whether his wife was a virgin when they had married, 46 years previously. His wife had disclosed that day, for the first time, that she was not. On this day Mr. Y left the house to play golf. He returned at around 09.30 hours knowing that his wife was out. He took between five and seven 7.5mg Zopiclone tablets; he then took a pipe and connected this to the exhaust of his car and switched on the engine. He later reported that he could see the fumes but nothing happened. He then took a canister of gas which he took into the car and opened the outlet valve once he had enclosed himself within the vehicle. Mr. Y had left a letter for his wife and family.

He was found by his daughter and wife at around 12.30 hours. He was reported to be very drowsy and confused when he was found.[4]

Mr. Y was seen in the Accident and Emergency Department by the on-call Psychiatric Senior House Officer (SHO). He told the SHO that he regretted his action and had no further suicide plans or ideas.

Mr. Y reported that he had felt stressed for around 15 years. He had been prescribed different medications but had found that Prozac (20mg in the morning) suited him best and had been prescribed this for approximately nine years. Mr. Y reported that he had never attempted to commit suicide before and had never been admitted to a psychiatric hospital. He had had a

3 Clinical notes, V1 p 99
4 Clinical notes V1 pp 52 & 55

psychotherapy appointment two to three weeks earlier and his next appointment was on **6 December** and he planned to call his therapist that evening.

Mr. Y reported that there was no history of mental illness in his family. He said that his father was very jealous and would not let mother out alone and that *"he couldn't join the army due to my mother."*

Mr. Y's speech was fluent and he reported that his mood was *"not too bad."* The SHO identified no biological symptoms of depression. Mr. Y denied that he had any suicidal or homicidal ideas; however his wife said that she did not believe that he was safe to return home.

The SHO recorded that Mr. Y presented a high risk of attempting to commit suicide. He consulted with the On-call Old Age Consultant Psychiatrist and it was agreed that an in-patient admission was appropriate.

Mr. Y's wife and daughter did not want Mr. Y to wait in the Accident and Emergency department for an ambulance so it was agreed that they would drive him to Orchard Ward, Harold Kidd Unit, Chichester where he was admitted.[5]

A risk screening assessment recorded that Mr. Y had no history of self harm and no known history of violence; he had acted impulsively and this was his first suicide attempt; he felt that he was a burden on his family and did not know what his family and friends would think about his actions. His wife had expressed concerns about his safety if he returned home. He was regarded as a being at high risk of attempting to commit suicide again as he had been determined to end his life earlier that day.[6]

Mr. Y was admitted to Orchard Ward, which was an older person's mental health ward, and an Older Person's Mental Health Simple Risk Assessment was completed. It was recorded that Mr. Y was experiencing emotional distress related to his relationship with his wife and he had attempted to commit suicide. He was not expressing ideas of helplessness or hopelessness, and was not expressing suicidal thoughts or plans. Mr. Y had been admitted to hospital because he needed a period of observation to ensure that his mental state remained settled. It was recorded that a Complex Risk Assessment was not required.[7]

On **27 November** the ward nurse recorded that Mr. Y was demanding to leave the ward before breakfast and could not be persuaded to wait to see a doctor. Under the circumstances she decided that it was most appropriate to detain him under section 5(4) of the Mental Health Act (1983) and the on-call doctor was called.[8]

Mr. Y was later assessed by the on-call SHO at 08.40 hours. Mr. Y said that he wanted to go home as he had no clothes. However Mr. Y later became tearful and said he was experiencing "*waves of reality and wished that he had never been found."*

5 Clinical notes V1 p 55
6 Clinical notes V1 p 61
7 Clinical notes V1 p 17
8 Clinical notes V1 p 109

The SHO recorded that:

(i) Mr. Y was not safe to leave the ward as he was still in an emotionally unstable state;
(ii) Mr. Y was experiencing high level of distress:
(iii) Mr. Y needed to be assessed by team doctor and his GP needed to be contacted as soon as possible as Mr. Y was not sure of medication he was on;
(iv) Mr. Y's Section 5(4) was converted into a Section 5(2).

The assessement continued at 10.20 hours and it was recorded that Mr. Y had met his wife when he was 20 years of age and she was 16. He had always been plagued by concerns that she had not been a virgin when they met and he blamed these concerns for the numerous affairs that he had had during their married life together. On the morning of 26 November Mrs. Y had confessed that she had not been a virgin when they first met. The distress this had caused led Mr. Y to make an attempt on his life.

As the morning progressed Mr. Y become less tearful and he stated that he would not try to kill himself again. The impression was recorded as:

"Attempted suicide due to:

(i) (?) Depression;
(ii) (?) Highly emotional/stressful situation".[9]

Later on the same morning the Consultant Psychiatrist (Consultant Psychiatrist 1) assessed Mr. Y. The events leading up to his suicide attempt were discussed. It was recorded that Mr. Y had longstanding psychological issues/personality traits that led to his problem in coping with wife's sexual history. He had been suspicious about this for the previous 46 years.

A 'West Sussex Older Person's Mental Health Simple Risk Assessment' was completed. It was written that Mr. Y needed a period of observation to ensure that his mental state remained settled but that a 'Complex Risk Assessment' was not required.[10]

It was recorded that he was calmer and able to discuss issues rationally and with insight. There was no evidence of significant depressive illness and he denied having suicidal ideas. He thought he could now forgive his wife and improve their relationship. Consultant Psychiatrist 1 explained that following such an emotional upset his mood would remain labile, and he may experience further episodes of distress and anger especially after talking with his wife. It was advised that he remain an in-patient for a few more days to allow his mood to settle in a safe and supportive environment; there were no grounds for detention identified. The plan was:

- *"continue usual medication;*
- *review later in the week – if remains settled discharge;*

9 Clinical Notes V1 p 74
10 Clinical Notes V1 p 17

- *if he tries to leave earlier contact … [Consultant Psychiatrist] for urgent discussion."*[11]

The Section 5(2) was rescinded.

On **29 November 2007** Mr. Y was reviewed again by Consultant Psychiatrist 1. It was recorded that he was no longer feeling suicidal or wishing to self harm. Mr. Y wanted to be moved off the ward as he did not find it to be therapeutic. His wife had begun making enquiries about private healthcare provision at The Priory. At this stage BUPA refused funding but Consultant Psychiatrist 1 said she would provide a report to facilitate the process. At this stage Mr. Y was happy to go to The Priory, but failing that, stated that he would prefer to be discharged the following day than continue on the Harold Kidd Unit. Discharge from the Unit was agreed to providing his wife would accept him home.[12] It was recorded that if Mr. Y was to be discharged then an early follow up would be required.

On **30 November** 2007 Consultant Psychiatrist 1 was on annual leave, however she had written a letter which was sent to Consultant Psychiatrist 2 at The Priory on this day. The letter set out Mr. Y's known psychiatric history and provided an account of recent events. It was stated that whilst Mr. Y had been expressing suicidal thoughts on admission, he had been settled over the past few days and was no longer expressing such ideas. However the letter went on to say that Mr. Y's wife was dissatisfied with her marriage and that Consultant Psychiatrist 1 was concerned that once this came to light (which she thought it would do in the near future) Mr. Y would self harm again. It was written that Mr. Y needed a longer period of inpatient admission in order to readjust to his circumstances particularly in relation to his marriage. He was reluctant to remain at the Harold Kidd Unit as he was on an older person's ward which he did not feel to be therapeutic. It was noted that BUPA would not fund outpatient follow up once discharged and that Consultant Psychiatrist 1 would be happy to provide this service as part of an ongoing NHS provision. It was advised that Mr. Y would benefit from a male therapist.[13]

Also on the **30 November** it was written in Mr. Y's clinical record that his daughter was worried about her mother's safety. She had described her father as being a clever and violent man who had expressed a desire to kill his wife and the man she had had her earlier relationship with. The daughter expressed fears about what would happen if her father was discharged. She explained that he had always been violent with all of his children: kicking; punching and whipping their heads against the wall. She also said that he had a habit of buying cars and losing a great deal of money on these deals. He had conducted 12 extra-marital affairs and suffered from extreme mood swings. His behaviour could be charming at times but he was also prone to losing his temper and becoming violent. This had led to him becoming isolated over the years with few friends. The daughter said that her father's word could not be trusted and that her mother tried a trial separation one month ago and was staying in a separate room since her return to the marital home. Mr. Y's wife had telephoned

11 Clinical Notes V1 p 77
12 Clinical Notes V1 p 79
13 Clinical Notes V1 pp 99-100

her daughter to say that Mr. Y had threatened to kill her during her visit on the ward the previous day and that he had planned to do this by smashing her over the head. He also said that he would then kill himself but that he could not execute this plan whilst he remained an inpatient.[14]

A Mental State Examination followed and it was recorded that Mr. Y admitted to having a plan to kill his wife and then himself. His plan focused upon being transferred to The Priory when he would first stop off at home, bludgeon his wife to death and then commit suicide. Mr. Y now felt that he had no option but to stay on the ward as he had disclosed his plan. He went on to deny he would commit suicide and said that he would be happy to stay in Hospital as an informal patient. The plan was for Mr. Y:

- to remain as an inpatient;
- to be placed on 15 minute observations;
- to be escorted when off the ward;
- to receive a psychiatric review if he attempted to leave the ward;
- to receive a Mental Health Act (1983) assessment.[15]

It was also advised that Mrs. Y should not visit the ward unescorted. It was recognised that Mr. Y could not be considered fit for transfer to The Priory at this stage.

At **15.15 hours** in the afternoon of the **30 November** a family meeting was held on the ward. Mr. Y's son and daughter were present and they stated that their father could not be trusted as he was manipulative and controlling and that their mother had already filed for a divorce and had consulted a lawyer. They also reported that two months earlier he had assaulted his wife by kicking her. His children explained that Mr. Y took little responsibility for his actions and that Mr. Y's son had informed the police about his concerns regarding the death threats.[16]

A 'West Sussex Older Person's Mental Health Simple Risk Assessment' was completed. It was noted that Mr. Y had threatened to kill his wife within the last 24 hours. The plan was to:

- maintain Mr. Y on 15 minute observations;
- to conduct a Mental Health Act (1983) assessment if he attempted to leave the ward;
- inform the Police if Mr. Y absconded from the ward;
- prevent Mrs. Y from visiting the ward.

It was not considered necessary for a 'Complex Risk Assessment' to be conducted at this stage. It was also noted that Mr. Y was not expressing ideas of helplessness or hopelessness and that he had no current plans for self harm whilst on the ward.[17]

A nursing Care Plan was developed. It was identified that Mr. Y had the potential to abscond and also to harm his wife. The plan was to:

14 Clinical Notes V1 pp 80-82
15 Clinical Notes V1 pp 83-84
16 Clinical Notes V1 p 84
17 Clinical Notes V1 pp 13-16

- complete the nursing assessment;
- ensure trained staff to spend half an hour with Mr. Y each day so he could ventilate his feelings;
- encourage Mr. Y to socialise with other patients;
- inform the Police if Mr. Y tried to discharge himself;
- remove all potently harmful objects;
- advise Mrs. Y not to visit over the next weekend;
- conduct 15 minute observations;
- monitor Mr. Y's mental state on a daily basis.[18]

On **3 December** it was recorded that Mr. Y had been settled on the ward over the weekend. It was noted that Mr. Y did not like to mix with other patients and preferred to spend his time in his room. It was recorded that the extreme thoughts he had experienced the previous week were no longer present and that his mood appeared to have improved. Mr. Y denied any thoughts of either self harm or harming others. Mr. Y stated that he no longer wanted to kill his wife; however it was decided to keep him on 15 minute nursing observations.

On **4 December** Mr. Y was reviewed by Consultant Psychiatrist 1. During the review Mr. Y said that he no longer had any serious homicidal intentions. He expressed regret about having spoken of his fantasy of killing his wife and he agreed to remain in hospital while the Psychiatrist discussed the situation with other relevant parties, including The Priory.

On the same day a Multidisciplinary Review took place. Consultant Psychiatrist 1 wrote that Mr. Y was cooperative with his care and that *"I can find no evidence of active mental illness. However family (wife and daughter) remain v. concerned about any thoughts of his discharge from hospital."*[19] The plan was to:

- request forensic assessment;
- request second opinion;
- check with The Priory regarding admission; and for Mr. Y to remain on Orchard ward while assessments took place.

Later on the same day Mr. Y's daughter telephoned the ward with concerns. She was worried that if her father returned home further arguments would take place which would place her mother at risk of violence. The family were in support of Mr. Y being transferred to The Priory.[20] Consultant Psychiatrist 1 telephoned the forensic service for an urgent assessment. She was informed that the service could only respond to emergencies and could not undertake an urgent request for assessment of dangerousness. Consultant Psychiatrist 1 was informed that Mr. Y would have to be referred to the forensic service where he would be considered and allocated if thought appropriate. If a more urgent response was required then either the Duty Consultant would have to be contacted or the Police. Consultant Psychiatrist 1 tried to contact three duty consultants but without success. She telephoned Mrs. Y to discuss whether

18 Clinical Notes V1 p 67
19 Clinical Notes V1 p 65
20 Clinical Notes V1 p 89

she had any fears should her husband be released and it was agreed to pursue admission to The Priory.[21]

The plan was recorded for Mr. Y to remain on Orchard ward as a voluntary patient for a period of assessment. The plan was:

- to continue pre-admission medication;
- for a further medical assessment to take place in a few days time.[22]

Also on this day The Priory Hospital requested a copy of Mr. Y's clinical records be sent to them. This was not done.

On **5 December 2007** an Older Person's Mental Health Simple Risk Assessment was conducted. The following was recorded:

- ***"Self Neglect or Injury:*** *No;*
- ***Self Harm/Suicide:*** *refer to Dr's assessment 30/11/07;*
- ***Antisocial Behaviour, e.g. hostility, violence, sexual disinhibition:*** *recent threats to wife, currently inpatient, on 15 minutes obs, wife visiting with family member, due to transfer to the Priory 6/12/07;*
- ***Wandering:*** *No;*
- ***Sensory Impairment:*** *No*
- ***Marked Physical Fragility, Falls:*** *No;*
- ***Unsafe Driving or driving against advice:*** *No;*
- ***Substance Misuse:*** *No;*
- ***Suspected Abuse by Others/Vulnerability:*** *No."*

It was assessed that Mr. Y would not be returning immediately to an environment that would place either Mr. Y or anyone else at risk. It was recorded that no Complex Risk Assessment was required.

Also on this day transfer information was sent to The Priory. One of Mr. Y's daughters emailed his Consultant Psychiatrist to say that her father could not be trusted, that he had a violent temper and that she feared he would carry our his threat to kill her mother. She was also of the view that calling the police would not in itself prevent her father.

At 11.00 hours on **6 December 2007** Mr. Y was transferred to The Priory Hospital. Mr. Y was transferred to an acute admission ward. The transfer was at the request of Mr. Y and his family who wanted private healthcare. He was subsequently transferred and discharged from the care of the Trust.

21 Clinical Notes V 1 p 90
22 Clinical Notes V1 p 70

10.2. Chronology: the Priory Hospital

The following information has been taken from the summary of the Coroner's proceedings as the Independent Investigation Team could not use Mr. Y's Priory clinical records.

The Priory Consultant Psychiatrist (Consultant Psychiatrist 2) met with Mr. and Mrs. Y in the afternoon of the **6 December**. The Consultant had already formulated in his mind that there were difficulties with their relationship. Mr. Y appeared to answer questions appropriately, maintain good eye contact and did not appear to be depressed. The plan was for Mr. Y to have Cognitive Behaviour Therapy. Mr. Y was not to be allowed unescorted leave from the hospital or to be alone with his wife. Mr. Y made it quite clear that he did not mean any of the previous threats he made to his wife.

The plan was for Mr. Y to stay at The Priory for 10 weeks and the Consultant Psychiatrist to see both Mr. and Mrs. Y together twice a week. It was noted that Mr. Y received other therapeutic interventions from other members of The Priory team but that the Psychiatrist was not aware of what this consisted of.

On **13 December** Mr. Y met with Consultant Psychiatrist 2 again. Mr. Y wanted to be discharged, but agreed to see the Consultant Psychiatrist as an outpatient. Mr. Y expressed no homicidal or suicidal ideation. At this stage Mrs. Y was not thought to be at risk. Mr. Y was subsequently placed on weekend leave. At this stage the Consultant Psychiatrist was satisfied that Mr. Y was suffering from pathological jealousy.

On the following Monday (**17 December**) Mr. Y returned from leave. He appeared to be well. On the **19 December** Mr. Y was discharged from The Priory Hospital. He was seen at an Outpatient clinic on the **20 December** where he appeared to be well.

On the **23 December** Mr. Y killed his wife and was then involved in a fatal car accident which claimed his life.

11. Identification of the Thematic Issues

11.1. Thematic Issues

The Independent Investigation Team identified 12 thematic issues that arose directly from analysing the care and treatment that Mr. Y received from the Sussex Partnership NHS Foundation Trust. These thematic issues are set out below.

1. **Diagnosis.** This is a case where diagnosis, or the lack of it, played a significant role in the failure to appreciate risk. Mr. Y was assessed as having an acute stress reaction and pathological jealously. Mr. Y's condition was not assessed in the context of his psychiatric history and the formulation did not acknowledge the chronic nature of his mental health problems.

2. **Medication and Treatment.** This appeared to have been appropriate considering the short period of time that Mr. Y was a patient with the Trust.

3. **Use of the Mental Health Act (1983 and 2007).** Mr. Y was detained twice under the Act whilst a patient with the Trust, once on Section 5(4) and once on Section 5(2), however he was transferred to The Priory without a Mental Health Act assessment being conducted. Considering that he had been detained a more in depth assessment was indicated. However this was made problematic by the fact that Mr. Y agreed to stay in hospital as a voluntary patient thereby obviating the need for an assessment under the Act. Whilst this thinking was logical it rather 'side stepped' Mr. Y's ongoing risk to both self and to others should he decide that he no longer wished to receive secondary care services.

4. **Care Programme Approach (CPA).** Mr. Y was a patient with the Trust for a total of eleven days. It is not possible to assess the quality of the CPA he received during this time.

5. **Risk/Clinical Assessment.** At the time of the incident the Trust's guidance relating to risk assessment and management was subsumed into the CPA policy and was not specifically developed to provide guidance about assessment and formulation. MARAC processes were not developed at this time therefore Mr. Y's threat to kill his wife was not assessed in the light of the risk that he presented to her and no protective measures with the police were jointly put into place.

   Most of the time Mr. Y appeared to be calm and charming and the risk to either himself or to his wife did not appear to be genuine; staff described them as *"fantasies."* However based on the fact that he had made a serious attempt on his life and had been detained under the Mental Health Act it would have been good practice to have undertaken a full risk assessment instead of the simple risk screen which was instead utilised. This constituted a failure to provide an adequate level of care.

6. **Referral, Admission, Transfer and Discharge Planning.** Mr. Y was admitted appropriately to an inpatient facility following his unsuccessful suicide attempt. Once on the Harold Kidd Unit it was evident that Mr. Y presented in an unusual manner for a person normally treated in an older person's facility. It became evident that Mr. Y was not happy on the Unit and wanted to leave.

   The NHS Trust Consultant Psychiatrist attempted to have Mr. Y referred to the forensic service for an emergency assessment. This attempt was to fail and Mr. Y was not seen by the service. There was an apparent lack of system for response to urgent forensic referrals despite recommendations form an earlier serious untoward incident report.

   Both Mr. Y and his family wanted a transfer to The Priory to take place. This was duly arranged. However whilst concerns had been raised about Mr. Y on the Harold Kidd Unit a robust set of assessments had yet to be undertaken prior to the transfer and no formulation had been made. Specific information about the levels of risk that Mr. Y presented with was not adequately communicated to The Priory. Therefore the transfer represented a transition where continuity was lost and important information did not travel with the patient.

7. **Service User Involvement in Care Planning and Treatment.** Mr. Y appeared to have been involved fully in his care and treatment and his wishes and needs were taken into full account during his time with the Trust.

8. **Carer Involvement.** Mr. Y was with services for a very short interval of time, and it is probable that had he been engaged with the service longer carer issues would have been addressed more fully. However it is of note that despite Mr. Y's children and wife voicing their concerns about his violence and levels of risk their concerns appear not to have been addressed. The prevailing thought was that Mr. Y's clearly articulated plans of violence were nothing more than a fantasy. The risks to the wife regarding domestic violence were not addressed. The internal investigation found that processes for working with the police at this time were weak. This contributed to the family's vulnerability.

9. **Documentation and Professional Communication.** The standard of written documentation appears to have been of a good standard. However the level of professional communication with The Priory and the GP were not of a standard which would have ensured a suitable continuity of care.

10. **Adherence to Local and National Policy and Procedure, Clinical Guidelines.** At the time Mr. Y received his care and treatment from the Trust there was no dedicated clinical risk assessment and management policy. This was not good practice.

11. **Clinical Governance and Performance**. It is difficult to understand how clinical governance practices worked within the Trust at the time of the incident due to the passage of time. However it was the conclusion of the Independent Investigation Team that clinical governance services at the present time are robust and fit for purpose.

12. **Summary of the Management of the Care and Treatment of Mr. Y.** Mr. Y's admission to the Harold Kidd Unit failed to provide an appropriate level of assessment in the context of the risk that he presented. The Independent Investigation Team did not however find any causal or contributory factors linked to the deaths of Mr. and Mrs. Y as Mr. Y's care and treatment continued after his discharge from the Harold Kidd Unit and there was opportunity for assessment and management processes to be developed further, and that any act or omission on the part of the NHS Trust did not in itself lead to a situation that could not have been mitigated against within the interval of time between Mr. Y's discharge and the deaths of both him and his wife.

12. Further Exploration and Identification of Contributory Factors and Service Issues

In the simplest of terms root cause analysis seeks to understand why an incident occurred. An example from acute care utilising the 'Five Whys' could look like this:

- serious incident reported = serious injury to limb
- immediate cause = wrong limb operated upon (ask why?)
- wrong limb marked (ask why?)
- notes had an error in them (ask why?)
- clinical notes were temporary and incomplete (ask why?)
- original notes had been mislaid (ask why?)
- (Because/possible reasons) insufficient resources to track records, no protocols or clear responsibilities for clinical records management = root cause.

Root cause analysis does not always lend itself so well to serious untoward incidents in mental health contexts. The Coroner found Mrs. Y's killing to be unlawful (no third party other than Mr. Y was implicated) and that Mr. Y's death was caused by suicide whilst suffering from a disturbed mind having been discharged as a voluntary inpatient at The Priory Hospital but remaining under care as an Outpatient.

RCA Third Stage

This section of the report will examine all of the evidence collected by the Independent Investigation Team. This process will identify the following:

1. areas of practice that fell short of both national and local policy expectation;
2. causal, contributory and service issue factors.

The terms 'causal factor', 'contributory factor' and 'service issue' are used in this section of the report. They are explained below.

Causal Factors: in the realm of mental health service provision it is never a simple or straightforward task to categorically identify a direct causal relationship between the quality of the care and treatment that a service user received and any subsequent homicide independently perpetrated by them. The term 'causal factor' is used to describe any act or omission that had a direct causal bearing upon the failure to manage a mental health service user effectively and a consequent homicide. No such finding was made in relation to the care and treatment Mr. Y received.

Contributory Factors: the term is used to denote a process or a system that failed to operate successfully thereby leading an Independent Investigation Team to conclude that it made a direct contribution to the breakdown to a service user's mental health and/or the failure to manage it effectively. These contributory factors are judged to be acts or omissions that created the circumstances in which a serious untoward incident was made more likely to occur. It should be noted that no matter how many contributory factors are identified it may

still not be possible to make an assured link between the acts or omissions of a Mental Health Care Service and the act of homicide independently perpetrated by a third party. No such finding was made in relation to the care and treatment Mr. Y received.

Service Issue: the term is used in this report to identify an area of practice within either the provider or commissioner organisations that was not working in accordance with either local or national policy expectation. Identified service issues in this report whilst having no direct bearing upon the deaths of Mr. and Mrs. Y need to be drawn to the attention of the provider and commissioner organisations involved in order for lessons to be identified and the subsequent improvements to services made.

12.1. Findings Relating to the Care and Treatment of Mr. Y

The findings in this chapter analyse principally the care and treatment given to Mr. Y by Sussex Partnership NHS Trust between the 26 November 2007 and 6 December 2007. The reader is referred to the narrative chronology for supporting information.

12.1.1. Diagnosis

12.1.1.1. Context

Diagnosis is the identification of the nature of anything, either by process of elimination or other analytical methods. In medicine, diagnosis is the process of identifying a medical condition or disease by its signs and symptoms, and from the results of various diagnostic procedures. Within psychiatry diagnosis is usually reached after considering information from a number of sources: a thorough history from the service user, collateral information from carers, family, GP, interested or involved others, Mental State Examination and observation.

The process of reaching a diagnosis can be assisted by a manual known as ICD 10. The International Statistical Classification of Diseases and Related Health Problems (most commonly known by the abbreviation ICD) provides codes to classify diseases and a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances and external causes of injury or disease as determined by the World Health Organisation. In the United Kingdom psychiatry uses the ICD 10 (10^{th} revision - published in 1992) Classification of Mental and Behavioural Disorders which outlines clinical descriptions and diagnostic guidelines to enable consistency across services and countries in the diagnosis of mental health conditions, ensuring that a commonly understood language exists amongst mental health professionals.

Diagnosis is important for a number of reasons; it gives clinicians, service users and their carers a framework to conceptualise and understand their experiences and difficulties as well as information and guidance on issues relating to treatment and prognosis. Having a defined

diagnosis is only part of the process of understanding and determining the treatment and management of a service user. It is critical to see the individual in their own context, and not only understand what they want from treatment and recovery but also support them in being central in decisions made about their care including risk management issues.

12.1.1.2. Findings

Findings of the Trust's Internal Investigation

The given working diagnosis (taken from The Priory notes) was Adjustment Disorder in respect of Mr. Y's reaction to Mrs. Y's previous sexual activity with a degree of pathological jealousy and a narcissistic style to his personality. Mr. Y also had a self-reported history of obsessional thoughts about his wife's pre-marital sexual relationships. The Trust internal Investigation did not offer any further analysis. It should be noted that this was not the diagnosis of the NHS Trust Consultant Psychiatrist.

Findings of the Independent Investigation

Mr. Y was admitted to Orchard Ward, an older person's facility, following an attempt on his own life. Whilst on the ward Mr. Y appeared to be a very angry man but not necessarily depressed. Mr. Y was devastated that his wife had recently confessed to having a sexual relationship with another man prior to having met him. On reflection ward staff could not state whether he was a smiling depressive or not, and the feedback from the family about his continued violence was at variance with how he presented on the ward where he appeared to be charming.

During the admission to Orchard Ward the family stated that at times, during the previous year, he appeared to be manic, buying and selling cars, and that he could be very convincing and manipulative. The family gave an account of Mr. Y's historic physical violence against both his children and his wife. They told the treating team that he could not be trusted and they took seriously his threats to kill Mrs. Y. However following the failure to get Mr. Y referred to the forensic service for assessment he presented as being well and the decision was made to transfer him to The Priory as this is what both he and his family wished. It was felt by the family that Mr. Y would do better with psychotherapy in a clinical environment for 'younger' people rather than being on an older person's ward.

Whilst the Coroner appeared to think that the Trust, the Police and The Priory had failed Mr. Y this was based on the notion that he was significantly mental ill at the time he killed his wife, a notion that the Trust could not support as no mental illness appeared to have been present.

However it was noted during an assessment that Mr. Y had harboured delusional thoughts about his wife over a number of years. It would appear that most of the clinical assessment Mr. Y was subject to focused upon depression when perhaps an examination of his chronic condition should have taken place. Had Mr. Y been viewed as a morbid jealously case then his attempted suicide and homicidal thoughts may have led to a different approach being taken and the recognition of potential risk heightened.

On the day of his transfer to The Priory it was recorded by Consultant Psychiatrist 1 that no *"active"* signs of mental illness could be detected. However based on what was known about Mr. Y a more in-depth formulation of the case was indicated which could have yielded a deeper insight into his mental state and any consequent risk that he may have presented with. This represents a significant failure.

Diagnostic Formulation

Mr. Y was diagnosed by Consultant Psychiatrist 1 as having an acute stress reaction. It was recognised that Mr. Y was emotionally unstable with high levels of distress. It was also recognised that Mr. Y had a history of depression for which he had been treated with Fluoxetine (an antidepressant) for nine years and that he also had history of long-standing psychological issues. Despite Mr. Y's recent suicide attempt and concerns voiced by his family that he was manic, no signs of mental illness were identified.

It should be noted however that an acute stress reaction denotes *"a transient disorder of significant severity which develops in an individual without any other apparent mental disorder in response to exceptional physical and/or mental stress and which usually subsides within hours or days."*[23] However Mr. Y's Trust Consultant wrote in her referral letter to The Priory that he had a long history of low mood for which he was being treated with Fluoxetine. The longstanding nature of Mr. Y's mental health history does not appear to have been taken into account when developing a formulation.

Whilst there was no evidence of psychotic features or delusional thinking when Mr. Y was on the Harold Kidd Unit, there was evidence of an obsessional preoccupation with his wife's premarital behaviour, a form of pathological jealousy within the morbid jealously spectrum. Michal Kingham and Harvey Gordon in the Royal College of Psychiatry journal for continuing professional development *Advances in Psychiatric Treatment* (2004) 10:207-215 state that morbid jealousy is a symptom rather than a diagnosis. The nature of its form, and other features evident from the history and mental state examination, should reveal the underlying diagnosis or diagnoses, and allow appropriate management. Morbid jealousy has the potential to cause great stress to both partners within a relationship and to their family. It carries the risk of serious violence and suicide. Consequently morbid jealousy requires effective management. It has to be recognised that prior to Mr. Y leaving the Harold Kidd Unit, whilst Mr. Y's jealously had been noted it had not been formulated as morbid jealousy (this was to be done a week later once Mr. Y was at The Priory). It was apparent however that he had experienced thoughts of killing his wife, that he suffered from jealousy, had acted impulsively, and harboured obsessional thoughts about his wife's premarital sexual activity.

12.1.1.3. Conclusions

The risk analysis based upon Mr. Y's diagnostic assessment was problematic in so far as he was an unreliable informant and did not tell the truth about how he was feeling and what he intended to do. The fact that Mr. Y denied homicidal/suicidal ideas was at odds with his

23. ICD 10 (10th revision - published in 1992) Classification of Mental and Behavioural Disorders F43.0

continued threats to his wife and his family's continued concerns about him. Mr. Y's case would have benefitted from the taking of a thorough psychiatric history as the information available was inherently contradictory. Mr. Y appeared to be a charming and articulate man on the ward but this was at variance with the fact that his wife appeared to be afraid of him and that his children expressed clear doubts about their mother's continued safety should Mr. Y be discharged and return home.

A diagnosis should always be made based upon the evidence available. In the case of Mr. Y the focus was upon a possible depression and an acute stress reaction. However it would seem that whilst additional information continued to present itself over an eleven-day period no review of Mr. Y's diagnosis or consequent risk was undertaken which considered whether a more deep-seated and chronic condition could be present.

It would not be reasonable to apply a hindsight bias to this case; however a more robust formulation was indicated based upon what was known about Mr. Y before he transferred to The Priory. Had this been achieved then a management plan could have been put into place. It should be noted that Consultant Psychiatrist 1 attempted to get a forensic service opinion but was unsuccessful in achieving this and consequently acquiesced to Mr. Y's transfer to The Priory. At this stage enough was known about Mr. Y to have merited a longer period of assessment. It was evident that Mr. Y did not wish to remain on the Harold Kidd Unit and that he did not appear to be suffering form a mental illness, therefore no involuntary detention under the Mental Health Act could be sanctioned. Mr. Y was willing to remain an inpatient, albeit at The Priory and this was duly arranged where it was expected that his assessment would continue.

It is unfortunate that at the point of discharge no clinical records were forwarded to The Priory. Consultant Psychiatrist 1 sent an informative referral letter, however this did not contain information about Mr. Y's threats to kill his wife. It should be stated however that The Priory Psychiatrist went on to make a detailed diagnosis, and that Mr. Y was transferred to an appropriate facility were he could continue to be assessed, monitored and treated. The Independent Investigation Team concludes that whilst the diagnostic picture was incomplete at the point of transfer, and that a robust formulation had not been made, this in itself neither caused nor contributed to the tragic events of the 23 December 2007.

- ***Service Issue One. The lack of diagnostic formulation meant that an incomplete picture of Mr. Y emerged which was based largely on his own unreliable account. During this period the Trust did not require older people's services to develop a formulation as part of an ongoing risk assessment process and in the case of Mr. Y this served to minimise the degree of risk that he presented.***

12.1.2. Medication and Treatment

12.1.2.1. Context

The treatment of any mental disorder must have a multi-pronged approach which may include psychological treatments (e.g. cognitive behaviour therapy, supportive counselling), psychosocial treatments (problem solving, mental health awareness, compliance, education, social skills training, family interventions), inpatient care, community support, vocational rehabilitation and pharmacological interventions (medication).

Psychotropic medication (medication capable of affecting the mind, emotions and behaviour) within the context of psychiatric treatments falls into a number of broad groups: antidepressants, antipsychotics, anxiolytics (anti-anxiety medication) and mood stabilisers.

Psychiatrists in the United Kingdom tend to use the Maudsley Prescribing Guidelines and / or guidance from The National Institute for Health and Clinical Excellence, as well as their own experience in determining appropriate pharmacological treatment for mental disorders.

In prescribing medication there are a number of factors that the doctor must bear in mind. They include consent to treatment, compliance and monitoring, and side effects.

Consent is defined as *"the voluntary and continuing permission of a patient to be given a particular treatment, based on a sufficient knowledge of the purpose, nature, likely effects and risks of that treatment, including the likelihood of its success and any alternatives to it. Permission given under any unfair or undue pressure is not consent"* (Code of Practice, Mental Health Act 1983, Department of Health 2008). Wherever practical it is good practice to seek the patient's consent to treatment but this may not always be available either because a patient refuses or is incapable by virtue of their disorder of giving informed consent.

When a patient is detained under the Mental Health Act under a Treatment Order (Section 3 or 37), medication may be administered without the patient's consent for a period of up to three months. Thereafter the patient must either give valid consent to treatment or must be reviewed by a Second Opinion Appointed Doctor (SOAD). The SOAD Service safeguards the rights of patients detained under the Mental Health Act who either refuse the treatment prescribed to them or are deemed incapable of consenting. The role of the SOAD is to decide whether the treatment recommended is clinically defensible and whether due consideration has been given to the views and rights of the patient. The SOAD is an independent consultant psychiatrist appointed by the Care Quality Commission.

The patient's ability to comply with recommended medications can be influenced by their level of insight, their commitment to treatment and level of personal organisation i.e. do they remember to take their tablets at the prescribed time. Antipsychotic medication can be given orally (in tablet or liquid form) or by depot (intramuscular injection) at prescribed intervals e.g. weekly / monthly. Depot medication can be particularly useful for those patients who

refuse to take the medication that is necessary for the treatment of their mental disorder, and / or who may be non compliant for whatever reason. It can be a way of ensuring that the patient has received medication and a protection from relapse.

All medication prescribed and administered should be monitored for effectiveness and also side effects. The most common side effects described for antipsychotic medications are called 'extra pyramidal' side effects i.e. tremor, slurred speech, akathisia and dystonia. Other side effects include weight gain and Electrocardiography (ECG) changes. Side effects can be managed by either reducing the dose of medication, changing to a different type of antipsychotic medication or by prescribing specific medication to treat the side effects.

12.1.2.2. Findings

Findings of the Trust's Internal Investigation

No specific findings were made by the Trust's internal investigation. However the Chief Executive wrote to one of Mr. and Mrs. Y's daughters in response to questions that she wanted addressed following the deaths of her parents. We have not had access to this letter but the response from the Trust clarified that:

- Mr. Y's Fluoxetine was continued once the treating team were aware he had been prescribed this by his GP and that initially ward staff were not aware he had his own medication on his person and which he continued to self-administer.
- Mr. Y was initially admitted for a period of assessment and observation during which time he was given regular opportunities to talk with ward nursing and medical staff to explore his thoughts and feelings and that he saw his Consultant Psychiatrist on a regular basis for interview and counselling sessions.

Findings of the Independent Investigation

Medication

The Independent Investigation Team found Mr. Y's medication regimen to be appropriate. During his stay at the Harold Kidd Unit Mr. Y was prescribed:

- Fluoxetine (an antidepressant) 40mg daily;
- Lisinopril (for high blood pressure) 10mg in the morning;
- Bisoprolol (beta blocker heart medication) 2.5mg in the morning;
- Simvastatin (a cholesterol lowering drug) 40 mg at night;
- Omeprazole (treatment for digestive disorders) 40mg in the morning;
- Zopiclone (treatment for insomnia) 7.5mg at night PRN.

Other Effective Evidence-Based Treatments

Mr. Y was admitted to the Harold Kidd Unit for a period of assessment and observation and plans were put in place to ensure his continued safety. During this period the ward staff approach was appropriate. A more intensive psychological therapy input could not have been commenced within the timeframes indicated.

However the Independent Investigation Team considered that Mr. Y's placement on a ward for older people did not constitute a therapeutic environment for him. This was a major factor

in Mr. Y wanting to be transferred to The Priory where he would be treated in, what both he and his family considered to be, a more age appropriate setting.

12.1.2.3. Conclusion

The Independent Investigation Team found the medication and treatment regimen Mr. Y followed to be appropriate. The Trust now operates an 'ageless service' and a person like Mr. Y would be admitted to an inpatient facility according to his presenting illness and levels of need; age alone would not be the primary determining factor.

12.1.3. Use of the Mental Health Act (1983 and 2007)

12.1.3.1. Context

The Mental Health Act 1983 was an Act of the Parliament of the United Kingdom but applied only to people in England and Wales. It covered the reception, care and treatment of mentally disordered persons, the management of their property and other related matters. In particular, it provided the legislation by which people suffering from a mental disorder could be detained in hospital and have their disorder assessed or treated against their wishes, unofficially known as 'sectioning'. The Act has been significantly amended by the Mental Health Act 2007.

At any one time there are up to 15,000 people detained by the Mental Health Act in England. 45,000 are detained by the Act each year. Many people who may meet the criteria for being sectioned under the Act are admitted informally because they raise no objection to being assessed and/or treated in a hospital environment. People are usually placed under compulsory detention when they no longer have insight into their condition and are refusing medical intervention and have been assessed to be either a danger to themselves or to others.[24]

Section 131 of the Mental Health Act (1983 and 2007) allows for people to be admitted into a psychiatric hospital on either a voluntary or informal basis, this means they can be treated without a compulsory detention order. Following the Bournewood findings in 2004 at the European Court of Human Rights a distinction was made between 'voluntary' and 'informal'. 'Voluntary' patients are people who are judged to have full capacity to consent or refuse consent to treatment; this means that they have the right to refuse all treatment and to discharge themselves from hospital at any time they wish. An 'informal' patient is a person who is judged as not having the capacity to give consent. This means that whilst they may raise no objection to being admitted and receiving treatment additional measures have to be taken to ensure their continued risk is contained and that their human rights are safeguarded. Many mental health Trusts in effect treat 'voluntary' and 'informal' patients in the same way.

24 Mental Health Act Commission 12th Biennial Report 2005-2007

Section 5 (4)
Section 5 of the Mental Health Act allows for emergency detention in order to give professionals more time to continue assessment. Section 5(4) allows a registered mental health nurse to detain an informal patient, of any age, who is an inpatient receiving treatment for mental disorder for up to six hours. It cannot be used in a general hospital if the patient is not mentally disordered and is receiving treatment for physical illness only. Section 5(4) can only be applied to inpatients who are still within the confines of the hospital, including its grounds. The holding power lapses upon the arrival of the doctor/approved clinician or at the end of six hours, whichever is earlier.

Section 5 (2)
Section 5(2) is a doctor's holding power. It can only be used to detain in hospital a person who has consented to admission on an informal basis (not already detained under the Act) but then changed their mind and wishes to leave. It can be implemented following a (usually brief) assessment by the Responsible Clinician or his deputy, which, in effect, means any hospital doctor, including psychiatrists but also those based on medical or surgical wards. It lasts up to 72 hours, during which time a further assessment may result in either discharge from the section, detention under Section 2 for assessment, or detention under Section 3 for treatment.

12.1.3.2. Findings
Findings of the Trust's Internal Investigation
No specific findings were made by the Trust internal investigation.

Findings of the Independent Investigation
On 26 November 2007 Mr. Y agreed to an informal admission to the Harold Kidd Unit following his suicide attempt; therefore no Mental Health Act assessment was deemed necessary. An assessment of 'Capacity and Consent to Assessment and Treatment Audit Form' was completed. Mr. Y was deemed to have the capacity, with normal cognitive functioning, to consent to his admission. Mr. Y was recorded as understanding why he needed to be in hospital for a period of assessment and that he agreed to stay. This was good practice.

At 08.30 hours on 27 November 2007 Mr. Y was detained under Section 5 (4) of the Mental Health Act. On this occasion Mr. Y had become tearful saying that he wanted to go home because he had no clean clothes to change into. Mr. Y did not want to wait to talk to a doctor and the nurse in charge of the ward did not think he was safe to go home. Mr. Y was told that he was going to be legally detained under Section 5 (4) of the Act. An absent without leave form was completed in the event that Mr. Y should leave the ward. This was good practice.

Mr. Y was seen by the on call Senior House Officer and was subsequently placed under Section 5 (2) of the Act at 9.00 hours. It was recorded that *"Pt needs to stay in hospital as there is a risk to himself. He made yesterday a serious suicide attempt, still expresses high*

level of distress and 'wish he never found' [sic] need further assessment by Consultant Psych."[25]

At 11.30 hours the Section was rescinded by the Consultant Psychiatrist who, following an assessment of Mr. Y, wrote *"Mr. Y is not displaying evidence of depressive illness or ongoing suicidal ideas. He is agreeable to remain on the ward informally for a further period of assessment."*[26]

During the following days it was recorded that Mr. Y had made threats to kill his wife and his family reported these threats directly to the Clinical Services Manager and Consultant Psychiatrist 1. During this period it was recorded that should Mr. Y attempt to leave the ward a Mental Health Act assessment would be considered, and/or the police called. Mr. Y was placed on 15 minute observations.

On 4 December 2007 during an interview with the Consultant Psychiatrist Mr. Y discussed his *"fantasy"* about killing his wife; he denied that he had any serious intention of acting upon it. However later the same day one of Mr. Y's daughters telephoned the Consultant Psychiatrist and expressed her concerns for her mothers continued safety should her father be released from hospital. It was agreed that a forensic assessment would be sought and a second opinion requested. During this period the arrangements for Mr. Y's transfer to The Priory continued.

In the event no forensic assessment could be arranged at short notice and no second opinion was pursued. It was good practice to have considered both of these measures. However the inability to access such support and the pending transfer to The Priory should not have been seen as valid reasons for no further assessment to be undertaken. At this stage one of two things should have been considered.

1. Mr. Y's transfer could have been delayed subject to a period of further assessment. If Mr. Y refused to consent to this then an assessment under the Mental Health Act could have been considered with a specialist second opinion sought.
2. The Consultant Psychiatrist at The Priory should have been told exactly what the ongoing concerns were and that a forensic assessment had been sought. At this point The Priory could either have refused to accept Mr. Y's admission or arranged for a forensic assessment as part of the continuing care and treatment plan.

The Independent Investigation Team acknowledges that the situation was highly unusual. A situation was in play whereby Mr. Y was making serious threats, and then denying having made them. No mental illness could be detected and Mr. Y was not refusing to remain on the Harold Kidd Unit as an informal patient in the short term, therefore no Mental Health Act detention could legitimately have been applied. A continuing period of assessment on the Harold Kidd Unit would have required Mr. Y's ongoing cooperation and it was unlikely that this would have been forthcoming; however it would have been good practice to have

25 Clinical Notes V1 p 138
26 Clinical Notes V1 p 136

explored this possibility in a robust manner, recorded the rationale and ensured the GP, the police and The Priory were informed.

12. 1.3.3. Conclusions

In the event Mr. Y was transferred to The Priory in accordance with both his and his family's wishes. At this stage Mr. Y remained a concern and an enigma. Consultant Psychiatrist 1 should have made explicit to The Priory the concerns that had been raised and that the management plan to get a specialist second opinion had failed to be implemented.

It cannot be known whether or not this approach would have altered the course of Mr. Y's assessment and treatment period at The Priory, or whether this would have affected the outcome of the events of 23 December 2007.

12.1.4. The Care Programme Approach

12.1.4.1. Context

The Care Programme Approach (CPA) was introduced in England in 1990 as a form of case management to improve community care for people with severe mental illness[27]. Since its introduction it has been reviewed twice by the Department of Health: in 1999 *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach* to incorporate lessons learned about its use since its introduction and again in 2008 *Refocusing the Care Programme Approach.*[28]

"*The Care Programme Approach is the cornerstone of the Government's mental health policy. It applies to all mentally ill patients who are accepted by specialist mental health services."*[29] (Building Bridges; DoH 1995) This is important to bear in mind as it makes the point that CPA is not only appropriate to those patients where more than one agency is likely to be involved, but to *all* patients receiving care and treatment.

The Care Programme Approach does not replace the need for good clinical expertise and judgement but acts as a support and guidance framework that can help achieve those positive outcomes for service users by enabling effective coordination between services and joint identification of risk and safety issues, as well as being a vehicle for positive involvement of service users in the planning and progress of their care. The Care Programme Approach is both a management tool and a system for engaging with people.

The purpose of CPA is to ensure the support of mentally ill people in the community. It is applicable to all people accepted by specialist mental health services and its primary function

27 The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services; DoH; 1990
28 Refocusing the Care Programme Approach, policy and positive practice; DoH; 2008
29 Building Bridges; arrangements for interagency working for the care and protection of severely mentally ill people; DoH; 1995

is to minimise the possibility of patients losing contact with services and maximise the effect of any therapeutic intervention.

The essential elements of any care programme include:

- systematic assessment of health and social care needs bearing in mind both immediate and long term requirements;
- the formulation of a care plan agreed between the relevant professional staff, the patient and their carer(s), this should be recorded in writing;
- the allocation of a Care Coordinator whose job is:
  - to keep in close contact with the patient
  - to monitor that the agreed programme of care remains relevant and
  - to take immediate action if it is not
- ensuring regular review of the patient's progress and of their health and social care needs.

The success of CPA is dependent upon decisions and actions being systematically recorded and arrangements for communication between members of the care team, the patient and their carers being clear. Up until October 2008 patients were placed on either Standard or Enhanced CPA according to their level of need.

12.1.4.2. Findings

Findings of the Trust's Internal Investigation

No specific findings on CPA were made by the Trust's internal investigation. However it was found that on the whole staff had the skills and abilities to carry out planned tasks effectively. There were clear signs of planning and the implementation of those plans. It was also noted that observation and therapeutic engagement good practice was followed. The Independent Investigation Team concurs with these findings.

Findings of the Independent Investigation Team

Mr. Y was on the Harold Kidd Unit for a period of only eleven days. It is unlikely whether Mr. Y would have been considered eligible for 'Enhanced' CPA and that following his discharge from The Priory he would probably have been followed up in the NHS Outpatient Clinic as opposed to a community mental health team as no severe or enduring mental illness had been identified. No CPA sections of Mr. Y's clinical record were completed and no Care Coordinator allocated.

However, whilst on the Harold Kidd Unit Mr. Y's day-to-day care planning appears to have been managed in a robust manner. A great deal of time and attention was given to assessing Mr. Y for nutritional needs, tissue viability and for falls; all in keeping with what would be usual on an older people's facility. In the case of Mr. Y this was clearly an inappropriate focus of attention.

An older persons' mental health 'Specialist/Comprehensive Assessment' was conducted but the form was left largely incomplete. It was evident that once again the assessment had been

developed with the frail older person in mind and that this was not an appropriate tool when assessing the needs of a person like Mr. Y. No alternative appears to have been considered.

Care plans were developed and clinical reviews held. Care Plans included:

1. **26 November 2007.** A multidisciplinary care plan was developed in relation to Mr. Y's admission. It was recorded that:
    - Mr. Y was to be admitted as an informal patient and that Consultant Psychiatrist 1 would continue to assess him.

2. **26 November 2007.** A nursing care plan was developed in view of Mr. Y's suicidal ideas and history of depression. It was recorded that:
    - Mr. Y's mood needed to be monitored;
    - a suicide risk assessment needed to be conducted;
    - 15 minutes observations were to be maintained;
    - Mr. Y was to be encouraged to socialise;
    - medication was to be provided;
    - a safe and therapeutic environment was to be maintained;
    - a relationship was to be developed with Mr. Y in order to build confidence.

3. **30 November 2007.** A nursing care plan was developed Mr. Y's potential for absconding and the consequent risk of harm to Mrs. Y. It was recorded that;
    - a risk assessment was required and that Mr. Y should have access to 30 minutes of qualified nurse time a day so he could discuss his feelings;
    - an evaluation was needed to understand his feelings, ideas and plans;
    - the police would be informed if Mr. Y absconded;
    - all potential objects for causing harm should be removed from Mr Y's bedroom;
    - Mr. Y's wife and son should be advised regarding visiting;
    - Mr. Y should be nursed on 15 observations;
    - the monitoring of Mr. Y's mood should continue and be reviewed on a daily basis.

4. **30 November 2007.** A nursing weekend treatment plan was developed to ensure:
    - Mr. Y had 30 minutes of nursing time each shift to ventilate his feelings, ideas and plans;
    - to encourage Mr. Y to come out of his bedroom and socialise with his fellow patients and staff;
    - to maintain 15 minute observations;
    - to alert the police if there was a potential for Mr. Y to abscond;
    - for Mrs. Y to be advised not to visit the unit over the weekend;
    - for Mr. Y's mood to be monitored and reviewed on a daily basis.

The Independent Investigation Team found the plans to be appropriate for the relatively short length of stay that Mr. Y had on the Unit and they also appear to have been implemented and monitored effectively.

12.1.4.3. Conclusions

No mention of CPA was made in Mr. Y's clinical record and it would appear that no CPA or Care Coordination arrangements were put in place. However this was reasonable in view of Mr. Y's presentation and relatively short length of stay with the service. Care planning was robust whilst on the Harold Kidd Unit and it was evident that Consultant Psychiatrist 1 maintained communication with The Priory and the GP and was prepared to continue with Mr. Y's ongoing care and treatment should he return back to the NHS. No causal, contributory or service issues were found in relation to the events of the 23 December 207.

12.1.5. Risk/Clinical Assessment

12.1.5.1. Context

Risk assessment and management is an essential and ongoing element of good mental health practice and a critical and integral part of the Care Programme Approach. Managing risk is about making good quality clinical decisions to sustain a course of action that when properly supported, can lead to positive benefits and gains for individual service users.

The management of risk is a dynamic process which changes and adjusts along the continuum of care and which builds on the strengths of the individual. Providing effective mental health care necessitates having an awareness of the degree of risk that a patient may present to themselves and/or others, and working positively with that.

The management of risk is a key responsibility of NHS Trusts and is an ongoing process involving and identifying the potential for harm to service users, staff and the public. The priority is to ensure that a service user's risk is assessed and managed to safeguard their health, wellbeing and safety. All health and social care staff involved in the clinical assessment of service users should be trained in risk assessment and risk management skills.

Clinical risk assessment supports the provision of high quality treatment and care to service users. It supports the provision of the Care Programme Approach and is a pro-active method of analysing the service user's past and current clinical presentation to allow an informed professional opinion about assisting the service user's recovery.

It is essential that risk assessment and management is supported by a positive organisational strategy and philosophy as well as efforts by the individual practitioner.

Best Practice in Managing Risk (DoH June 2007) states that *"positive risk management as part of a carefully constructed plan is a desirable competence for all mental health practitioners, and will make risk management more effective. Positive risk management can*

be developed by using a collaborative approach … any risk related decision is likely to be acceptable if:

- *it conforms with relevant guidelines;*
- *it is based on the best information available;*
- *it is documented; and*
- *the relevant people are informed."*[30]

As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at that time.

Effective and high quality clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and /or others, or of being harmed. The assessment and management of risk should be a multidisciplinary process which must include where possible and appropriate the service user and their carer. Decisions and judgements should be shared amongst clinical colleagues and documented clearly, particularly when they are difficult to agree.

Sussex Partnership NHS Trust Policy

At the time Mr. Y received his care and treatment from the Trust there was no 'stand alone' risk assessment and management policy. Guidance was provided within the CPA policy. Each separate service used a different set of risk assessment tools.

12.1.5.2. Findings

Findings of the Trust's Internal Investigation

It was found that assessment of potential violence and aggression processes were not developed to any extent in older people's services. The Independent Investigation Team concurred with this finding.

Findings of the Independent Investigation Team

At the time Mr. Y received his care and treatment from the Trust the guidance relating to risk assessment and management was subsumed into the CPA policy and was not specifically developed to provide guidance about assessment and formulation. MARAC processes were not developed at this time therefore Mr. Y's threat to his wife was not assessed in the light of the risk that he presented to her and no multiagency protective measures were put into place.

Events History and Clinical Risk Assessment

The Trust's lack of specific risk assessment and management policy guidance was compounded by the fact that Mr. Y was admitted onto an older person's ward. The risk assessments in place at the time for older peoples' services were focused primarily on the

30 Best Practice in Managing Risk; DoH; 2007

risks normally associated with the physically frail older person. The tools used did not prompt a more in depth examination of Mr. Y's presentation.

The initial risk screening assessment that took place on the 26 November 2007 noted that there had been no other previous attempts on Mr. Y's life. The assessment stated that Mr. Y was no longer expressing suicidal ideas and that he was not expressing high levels of distress. However the summary concluded that Mr. Y was at high risk and had acted impulsively, the need for an inpatient admission was identified.

Following Mr. Y's admission to the Harold Kidd Unit on 26 November 2007 a 'Simple Risk Assessment' was conducted. On this occasion Mr. Y's history of previous mental illness was noted; Mr. Y's risk of suicide was assessed as being low but a suicide risk assessment was also completed. This identified that Mr. Y was experiencing relationship difficulties with his wife and that he had made a previous attempt on his life. It was recorded that he had no plans to harm himself again. No further actions were deemed necessary. It was not thought that a complex risk assessment was required.

On 30 November 2007 a 'Simple Risk Assessment' was conducted. It was noted that Mr. Y had threatened to kill his wife and admitted he had a homicide/suicide plan. It was recorded in the margin of the assessment that if Mr. Y attempted to leave the ward a Mental Health Act assessment would be conducted and the police informed. At this stage his wife was to be discouraged from visiting and Mr. Y was placed on 15 minute observations. It was not thought that a complex risk assessment was required; however the pending transfer to The Priory was delayed at this point so that further assessment could take place.

The letter sent by Consultant Psychiatrist 1 to The Priory Psychiatrist on the 30 November 2007 identified that Mr. Y may be a continued risk regarding self-harm and this could be exacerbated in the future once his wife made clear that she was dissatisfied with the marriage, a fact Mr. Y was not yet party to. No mention of any risk to Mrs. Y was made either in this letter or the referral report which had been prepared the previous day. The Inquest heard however that the letter had been written before the Consultant Psychiatrist knew of the threats to Mrs. Y but that she did telephone The Priory Clinical Service Manager to ascertain whether or not these threats would preclude Mr. Y from being transferred. No record of this conversation was made in the clinical notes. No *"direct communication about the threats"* took place between the two Consultant Psychiatrists.[31]

On 4 December 2007 following assessment it was decided that a forensic assessment and a second opinion would be sought in order to assess Mr. Y's levels of dangerousness. In the event this could not be arranged.

On 5 December 2007 a 'Simple Risk Assessment' was conducted. On this occasion no risks were identified other than that Mr. Y had relationship difficulties, was on medication for his

31 Coroners Record

psychiatric condition and had made a previous attempt on his life. It was noted however that Mr. Y had made recent threats to harm his wife and that due to these threats his wife was not to assist in the transfer to The Priory due to take place the next day and that nurse would provide the escort. It was not thought that a complex risk assessment was required.

Also on 5 December 2007 one of Mr. Y's daughters emailed the NHS Trust Consultant Psychiatrist following an earlier conversation that had taken place. She said

> *"I do not wish to be alarmist, but he has clearly spoken of not just killing his wife, but how he planned to do it…he is a man who will go to extreme lengths to prove a point. He can be violent…I do not want this to be another front page news story of everyone trying to warn doctors of the danger and the patient being allowed out to commit murder and suicide."* [32]

No changes to Mr. Y's management plan were made as a result of the daughter's concerns. However the moves to transfer Mr. Y to the Priory were stepped up as this was thought to be a suitable preventative tactic by Mr. Y's daughter who had stated in her email that *"…is it not worth using this in patient care [at the Priory] for him offered by BUPA in the vain hope of providing as much help for him as possible and staving off the very real possibility of the death of both of my parents."*[33]

Management Plans - Process and Procedure

Whilst on the Harold Kidd Unit, for the majority of the time, Mr. Y appeared to be calm and charming and the risk to either himself or to his wife did not appear to be genuine, staff described them as *"fantasies."* However based on the fact that he had made a serious attempt on his life and had been detained under the Mental Health Act it would have been good practice to have undertaken a full risk assessment instead of a simple risk screen. It is also a fact that the family came forward with serious concerns about Mr. Y's past physical violence towards both his children and his wife. It was apparent that the family took his threats to kill his wife seriously. This alone should have merited a full risk assessment to have been undertaken and NHS-led liaison with the police should have been triggered.

The national MARAC arrangements post dated the deaths of Mr. and Mrs. Y therefore this process was not available to the treating team. It is a fact that the family reported Mr. Y to the police who in the event were not able to prevent the incident from occurring. Had there been corroborating evidence to support the family's report from the Trust, especially since a forensic referral had been deemed to be necessary, then the matter might have been taken more seriously by the police. There are significant lessons for learning. Full risk assessments are required for all service users regardless of age when:

- when a serious suicide attempt has been made;
- a person requires detention under Act;

32 Clinical Notes V1 p 104
33 ibid

- the family/carer comes forward with serious concerns about the person's safety or risk of violence towards others.

12.1.5.3. Conclusions

Whilst Mr. Y was an inpatient at the Harold Kidd Unit the threat to his wife was not assessed in the light of the continued risk that he posed to her and no protective measures (other than the most basic) were put into place. A more robust diagnostic formulation should have identified that Mr. Y's presentation indicated a propensity for violence and self harm. At the point of Mr. Y's transfer to The Priory a great deal was known about him but nothing had been pulled together into a formulation and the opportunity to seek a second opinion was not pursued beyond a rudimentary level.

Mr. Y was transferred to The Priory without a clear and explicit of assessment of his risk profile being communicated to his new treating team; the assumption was made that the family would provide the briefing. This was unacceptable practice. It was evident however that once at The Priory the risks Mr. Y presented were made immediately known to his new treating team by the family and therefore it cannot be said that they went uninformed. However there appeared to be a degree of scepticism on the part of The Priory as to the veracity of Mr. Y's levels of risk. It is possible that had this been communicated by the NHS Trust Consultant Psychiatrist the information would have been regarded as having a higher degree of credibility and would have been taken more seriously. However Mr. Y left the NHS Trust three weeks prior to the deaths of Mr. and Mrs. Y and sufficient was known about Mr. Y at The Priory to have merited a risk management plan being put into place regardless of what had or had not been communicated at the point of the transfer. Therefore the Independent Investigation Team could find no causal or contributory factors on the part of the NHS Trust and the deaths of Mr. and Mrs. Y. However it was concluded that risk assessment and management processes were poor and fell below the standards to be expected from a mental health service.

- ***Service Issue Two. Poor Trust risk assessment and management systems meant that Mr. Y did not receive a robust risk assessment in the context of his diagnostic formulation. This meant that his levels of risk were neither identified nor managed sufficiently whilst at the NHS Trust, and communication was not managed appropriately at the point of his transfer to The Priory.***

- ***Service Issue Three. Trust procedures regarding communication with the police were unclear and under developed and could not ensure that the concerns about Mr. Y that were made known to the NHS were passed on and managed in an appropriate and timely manner.***

12.1.6. Referral, Transfer and Discharge Planning

12.1.6.1. Context

Referral, transfer and discharge all represent stages of significant transition for a service user either being accepted into a service, being transferred between services or leaving a service once a care and treatment episode has been completed. These occasions require good consultation, communication and liaison. It should be no surprise that these stages form critical junctures when delays can occur, information can be lost and management strategies communicated poorly. Explicit policies and procedures are required in order to ensure that these critical junctures are managed effectively.

12.1.6.2. Findings

Findings of the Trust's Internal Investigation

Mr. Y was a 66-year old man, therefore admitted to an older people's service, however his clinical needs may have been better met in an adults' of working age facility. It was also found that there was an apparent lack of system for response to urgent forensic referrals despite recommendations from an earlier serious untoward incident report.

Findings of the Independent Investigation Team

Mr. Y was admitted in a timely manner as an inpatient following his suicide attempt. Mr, Y was admitted to the Harold Kidd Unit which was a facility for older people. However despite Mr. Y being 66 years old his needs were those of a person of working age rather than those of an older adult. Mr. Y did not want to stay on the Harold Kidd Unit preferring a transfer to The Priory. It is entirely possible that his case might have been assessed differently and his risks managed in amore robust manner had he not been admitted to an older peoples' facility.

Consultant Psychiatrist 1 nonetheless tried to refer for an urgent forensic service assessment, albeit unsuccessfully. The referral was made following Mr. Y making threats to kill his wife and was for an assessment of dangerousness as well as to ascertain whether or not he should be considered for detention under the Mental Health Act. However it was apparent that the assessment could not be undertaken with immediate effect and that a period of some six days would have to pass before the referral could be considered at the forensic service Monday allocation meeting. It is not clear why Mr. Y's Consultant Psychiatrist did not try to access one of the forensic service clinicians directly instead of making her request through a member of the administrative team. Neither is it clear why Mr. Y's transfer to The Priory was not delayed for another week until this referral was processed and Mr. Y assessed. Whilst it was thought that Mr. Y did not have a mental illness sufficient concern had been raised to refer him to the forensic service. It would have been good practice to have least developed a plan which sought to delay Mr. Y's transfer until such an assessment had been made and to have assertively followed this up. In the event the Consultant Psychiatrist did not pursue the referral.

Transfer to The Priory appears to have been undertaken at Mr. Y's family's request. However no Mental Health Act assessment had been conducted and it was as a result of this transition that concerns about Mr. Y's risk appear to have been down graded. Whilst referrals to The Priory were not unusual it was rare for an individual to be transferred who was self-funding. This appeared to have impacted negatively upon continuity of care. At this stage within the NHS service there was a high degree of caution about how much risk information should be sent with the patient when transferring to the private sector due to notions regarding confidentiality. Consequently Mr. Y was transferred without any explicit clinician-to-clinician discussion held about his levels of ongoing risk and no copy of his clinical record was provided.

12.1.6.3. Conclusions

Mr. Y stated whilst on the Harold Kidd Unit his plans to kill both his wife and himself; these plans were taken seriously by his family. Knowing this was something he had been talking about in recent days, and in the context of his suicide attempt, the plans to transfer him to The Priory should either have been postponed and/or required a more robust level of liaison. The police service should also have been notified directly. It is difficult to assess what could or should have been managed differently without a hindsight bias. However based upon what was known at the time the transfer should perhaps have been deferred until a longer period of assessment had been undertaken by the forensic service. That being said it is difficult to know whether Mr. Y would have cooperated and whether he could legitimately have been detained prior to a forensic assessment taking place if he chose to leave the Unit. Unfortunately no management plan was developed to manage these eventualities and Mr. Y was transferred by default in the absence of any other approach being considered. At the point of transfer a certain degree of continuity was lost. However The Priory treating team was soon made aware of the situation by Mr. Y's family and had an opportunity to make an assessment and develop a management plan regardless of what had or had not been communicated at the point of the transfer. Therefore the Independent Investigation Team could find no direct causal or contributory factors due to any failings of the NHS Trust and the deaths of Mr. and Mrs. Y. However it was concluded that referral and transfer processes were poor and fell below the standards to be expected from a mental health service.

- ***Service Issue Four. At the time Mr. Y received his care and treatment from the Trust all adults above the age of 65 years were placed with the older peoples' service. This occurred regardless of clinical need and presentation. Mr. Y found himself in a facility which could not provide the level of assessment and management that he needed and one which both he and his family found to be inappropriate for him, hence wanting him to be transferred to The Priory.***

- ***Service Issue Five. Referral processes for emergency assessment with forensic services did not operate in a timely manner leaving the NHS Trust Consultant Psychiatrist without access to a specialist second opinion.***

- ***Service Issue Six. The transfer process between the NHS Trust and The Priory was not managed well in that professional communication was limited and no copy of***

Mr. Y's clinical records were sent. This meant that an incomplete picture of Mr Y was given and continuity lost.

12.1.7. Service User Involvement in Care Planning and Treatment

12.1.7.1. Context

The engagement of service users in their own care has long been heralded as good practice. The NHS and Community Care Act 1990 stated that:

"… the individual service user and normally, with his or her agreement, any carers, should be involved throughout the assessment and care management process. They should feel that the process is aimed at meeting their wishes."

In particular the National Service Framework for Mental Health (DH 1999) stated in its guiding principles that *"…people with mental health problems can expect that services will involve service users and their carers in the planning and delivery of care"*. It also stated that it would *"… offer choices which promote independence."*

12.1.7.2. Findings

Findings of the Trust's Internal Investigation

No findings were made by the Trust's internal investigation.

Findings of the Independent Investigation Team

Mr. Y appeared to have been involved fully in his care and treatment and his wishes and needs were taken into account during his time with the Trust. It is unfortunate that he was placed on an older person's ward which he found to be inappropriate and unpleasant. This meant that the service itself was not designed to meet his needs and address his choices.

Mr. Y was described as being charming and manipulative by his family and his NHS Consultant Psychiatrist observed that he would probably do better with a male therapist in the future as he would attempt to charm a woman and would not focus on his treatment. Despite these factors being recognised Mr. Y was able to deceive his treating team and created a false impression of his thoughts and feelings which went undetected.

12.1.7.3. Conclusions

Mr. Y was treated with dignity and respect whilst on the Harold Kidd Unit, this was good practice. However Mr. Y was taken at face value, whether or not this was as a result of his being a relatively young man on older person's ward cannot be known. Mr. Y was able to manipulate his treating team into not detaining him under a section of the Mental Health Act by staying as a voluntary patient and by claiming his plans to kill both his wife and himself were a mere fantasy. It is a lesson for learning that when a service user presents in a contradictory manner, for example with high levels of distress, a serious suicide attempt and making threats to kill, some scepticism is merited when they suddenly present in an entirely different manner as Mr. Y did literally within a matter of hours. Working to meet the wishes

of a service user is not the same thing as ensuring that their treatment needs are met based on a comprehensive assessment.

12.8. Family Concerns and Involvement

12.1.8.1. Findings

Findings of the Trust's Internal Investigation

No findings were made by the Trust's internal investigation.

Findings of the Independent Investigation Team

There are two factors which require consideration. The first is that Mr. Y's family expressed consistent and persistent concerns about the level of risk he presented to his wife. The family were in no doubt that would kill Mrs. Y and then go on to kill himself. It is evident that the family were feeling frustrated and frightened as evidenced in the email sent by one of Mr. Y's daughters to the NHS Consultant Psychiatrist on 4 December 2007 (please see the section on risk above). These concerns were perceived to be significant enough for a forensic second opinion to be sought but not for a robust risk management plan to be put into place. It should be noted that the treating team did not report the concerns to the police leaving the family to do so if they thought the risk was significant enough. This left the family account made to the police unsubstantiated by Mr. Y's treating team and the family unsupported.

The second factor was that the family wanted Mr. Y to be transferred to The Priory as they thought the Harold Kidd Unit could not provide a therapeutic environment for him. The family were also concerned that as the Trust could find no mental illness and were unable to detain Mr. Y under the act he would be discharged and Mrs. Y would be placed at risk. The family's wish for Mr. Y to be at The Priory appears to have hastened the transfer even though it was evident that a longer period of assessment was indicated.

12.1.8.3. Conclusions

In the event it would appear that the treating team chose to believe Mr. Y, who stated his plans to kill his wife were simply a 'fantasy', over and above his family, who knew he had a propensity for violence and was serious about carrying out his threats. The processes for the Trust working with the police at this time were weak and this contributed to the family's vulnerability. It was evident that the concerns and needs of the family were not addressed and were seen as something quite separate to the care and treatment that was being delivered to Mr. Y.

Paradoxically however the wishes of the family in transferring Mr. Y to The Priory were acquiesced with rapidity even though this may not have been in his best interests or that of his wife.

12.1.9. Documentation and Professional Communication

12.1.9.1. Context

Documentation

The General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) have issued clear guidance regarding clinical record keeping. All of the other statutory regulatory bodies governing all other health and social care professionals have adopted similar guidance.

The GMC states that:
"Good medical records – whether electronic or handwritten – are essential for the continuity of care of your patients. Adequate medical records enable you or somebody else to reconstruct the essential parts of each patient contact without reference to memory. They should be comprehensive enough to allow a colleague to carry on where you left off." [34]

Pullen and Loudon writing for the Royal College of Psychiatry state that:
"Records remain the most tangible evidence of a psychiatrist's practice and in an increasingly litigatious environment, the means by which it may be judged. The record is the clinician's main defence if assessments or decisions are ever scrutinised."[35]

Professional Communication

"'Effective interagency working is fundamental to the delivery of good mental health care and mental health promotion."[36]

Jenkins *et al* (2002)

Jenkins *et al* describe the key interagency boundary as being that between secondary and primary care. The Care Programme Approach when used effectively should ensure that both interagency communication and working takes place in a service user-centric manner.

Since 1995 it has been recognised that the needs of mental health service users who present with high risk behaviours and/or have a history of criminal offences cannot be met by one agency alone.[37] The *Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994) criticised agencies for not sharing information and not liaising effectively.[38] The Department of Health *Building Bridges* (1996) set out the expectation that agencies should develop policies and procedures to ensure that information sharing can take place when required.

34 http://www.medicalprotection.org/uk/factsheets/records
35Pullen and Loudon, *Advances in Psychiatric Treatment*, Improving standards in clinical record keeping, 12 (4): (2006) pp 280-286
36 Jenkins, McCulloch, Friedli, Parker, *Developing a National Mental Policy*, (2002) p121
37 Tony Ryan, *Managing Crisis and Risk in Mental Health Nursing*, Institute of Health Services, (1999) p 144.
38 Ritchie *et al Report of the Inquiry into the Care and Treatment of Christopher Clunis* (1994)

12.1.9.2. Findings

Findings of the Trust's Internal Investigation

No system was in place to instigate liaison with the police with regard to patients who may be exhibiting offending behaviours on older people's units.

Findings of the Independent Investigation Team

Documentation

The Independent Investigation Team found the standard of clinical record keeping to be of a good general standard. However some of the assessment forms were not completed and there appeared at times to be an over reliance on medical assessments which meant nursing staff either replicated them or referred to them without contributing new and relevant information as it emerged.

Professional Communication and Interagency/Service Liaison

There were no processes in place to ensure that the older people's service could liaise with the police if potential offending behaviours were identified. This meant that in Mr. Y's case there was no guidance to follow and the family was left to report their concerns to the police without either formal corroboration or support being offered by the Trust. This may have served to 'down play' the seriousness of the concerns raised by the family.

At the point of Mr. Y's transfer to The Priory a limited amount of liaison occurred. It would appear that no direct and explicit communication took place between the two Consultant Psychiatrists. This was regrettable as it was left to Mr. Y's family to ensure that The Priory was made aware of his level of risk. This situation was made worse by the fact that Mr. Y's clinical notes were not copied and sent with him at the point of transfer due to a misguided belief that the NHS team would be breaching patient confidentiality in some way.

12.1.9.3. Conclusions

The Independent Investigation Team concluded that the general level of professional communication on the part of the NHS Trust was poor. This meant that concerns were not raised in an appropriate manner to the police or passed onto The Priory which would have ensured a better continuity of care.

- ***Service Issue Seven. During the period in which Mr. Y received his care and treatment from the NHS Trust there were no protocols in place to inform practitioners how best to liaise with the both the police and the private sector in relation to reporting ongoing concerns about the service users in its care. This served to prevent important information about Mr. Y from being shared in a timely manner with services which could have ensured further assessment was made and the necessary management plans put into place.***

12.1.10. Adherence to Local and National Policy and Procedure

12.1.10.1. Context

Evidence-based practice has been defined as *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."*[39] National and local policies and procedures are the means by which current best practice evidence is set down to provide clear and concise sets of instructions and guidance to all those engaged in clinical practice.

Corporate Responsibility: policies and procedures ensure that statutory healthcare providers, such as NHS Trusts, make clear their expectations regarding clinical practice to all healthcare employees under their jurisdiction. NHS Trusts have a responsibility to ensure that policies and procedures are fit for purpose and are disseminated in a manner conducive to their implementation. NHS Trusts also have to ensure that healthcare teams have both the capacity and the capability to successfully implement all policies and procedures and that this implementation has to be regularly monitored regarding both adherence and effectiveness on a regular basis. This is a key function of Clinical Governance which is explored in section 12.1.11. below.

Team Responsibility: clinical team leaders have a responsibility to ensure that corporate policies and procedures are implemented locally. Clinical team leaders also have a responsibility to raise any issues and concerns regarding the effectiveness of all policies and procedures or to raise any implementation issues with immediate effect once any concern comes to light.

Individual Responsibility: all registered health and social care professionals have a duty of care to implement all Trust clinical policies and procedures fully where possible, and to report any issues regarding the effectiveness of the said polices or procedures or to raise any implementation issues as they arise with immediate effect.

12.1.10.2. Findings

Findings of the Trust's internal Investigation

The Trust's internal investigation found during the time Mr. Y received his care and treatment from the Trust risk assessment and management guidance was subsumed into the CPA policy and no sufficient level of evidence-based direction was available to practitioners.

Findings of the Independent Investigation Team

The Independent Investigation Team concurs with findings of the Trust internal investigation process. The Trust policies as they pertained to risk assessment and management were not robust enough to have provided adequate guidance when formulating the risk profile of a service user such as Mr. Y. This was of particular note as the risk assessment format used by

39 Callaghan and Waldock, *Oxford handbook of Mental Health Nursing*, (2006) p 328

the older people's service at the time focused mainly upon the risks associated with the physically frail older person.

In addition there was an absence of communication protocols which could have provided guidance to mental health services when notifying the police about service users whose level of risk could lead to offending behaviours. There was also a lack of clarity about how older people's services conducted the transfer of service users to the independent sector and how to manage the sharing of clinical information.

12.1.10.3. Conclusions

The Independent Investigation Team concluded that all of the clinical staff involved in providing care and treatment to Mr. Y adhered to the policies and procedures that were available to them. However the good practice and evidence-based guidance provided by the Trust was not robust enough to provide sufficient direction.

- ***Service Issue Eight. The Trust did not have in place sufficiently robust evidence-based policy guidance to direct clinical staff. This impacted upon the quality of the risk assessment that Mr. Y received and upon communication and liaison processes with the police and The Priory.***

12.1.11. Clinical Governance and Performance (to include clinical supervision, professional leadership and organisational change)

12.1.11.1. Context

"*Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish."*[40]

NHS Trusts implement clinical governance systems by ensuring that healthcare is delivered within best practice guidance and is regularly audited to ensure both effectiveness and compliance. NHS Trust Boards have a statutory responsibility to ensure that the services they provide are effective and safe.

During the time that Mr. Y was receiving his care and treatment the Trust would have been subject to two main kinds of independent review from the then NHS Regulator. The first kind of review took the form of an annual performance ratings exercise and the second kind took the form of a Clinical Governance evaluation. The reader is asked to look at the Care Quality Commission website for more information as to how the national performance framework is managed.

40 Department of Health. http://www.dh.gov.uk/en/Publichealth/Patientsafety/Clinicalgovernance/DH_114

It is not the purpose of this Investigation to examine closely all of the Clinical Governance issues relating to the Trust prior to the deaths of Mr. Y. The issues that have been set out below are those which have relevance to the care and treatment that Mr. Y received.

12.1.11.2. Findings

The following information has been taken from the Trust's 2012/1013 Annual Quality Report.

The Trust sets itself 'stretch' targets on all aspects of quality, via annual objectives, each with markers and measures. Progress is reviewed at the Trust Board on a monthly basis to ensure corrective action is taken where needed.

Priorities for Improvement 2012/2013

These include:

- treating service users with dignity and respect;
- a compassionate and caring approach;
- safe environments;
- providing care and treatment that staff and patients would recommend to their family and friends.

These quality markers are measured and examined at every Board meeting by the use of a summary dashboard.

Priorities for Improvement for 2013/2014

These include:

- improving the patient experience (the Trust is working with the friends and family test introduced by David Cameron in 2012 to ensure that all services are improved);
- safety (the safety thermometer developed as a result of the Staffordshire Inquiry is used and the Trust works closely with the Clinical Commissioning Groups to ensure incidents are managed properly);
- effectiveness (services are in the process of being aligned to outcome focused care pathways which incorporate National Institute of Clinical Excellence guidance, this is linked to Payment by Results and Commissioning for Quality Improvement requirements).

Care Quality Commission (CQC)

Sussex Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'without condition'. The Care Quality Commission has not taken enforcement action against Sussex Partnership during 2012-13.

Mr. Y Investigation Report

The Trust has participated in special reviews and investigations by the Care Quality Commission during 2012-13 in relation to the management of ligature anchor points at the Department of Psychiatry, Eastbourne and Mill View Hospital, Hove.

Follow up special reviews and investigation visits took place in March 2013. Inspection reports have been shared for Mill View Hospital and the Department of Psychiatry, which demonstrate the essential standards of Care and welfare of people who use services and safety and suitability of premises have now been met. The CQC's judgement was that patients received safe, appropriate and personalised treatment and support through the coordinated assessment, planning and delivery of care at both locations. Since the last inspections the locations have improved the care planning documentation and the inspection reports note that care plans documented the plan of treatment and reflected the care and support people received.

The inspection reports reflect that the CQC are satisfied that there are systems in place to manage both individual and environmental risks at the locations. The CQC were satisfied that the hospitals had undertaken a major programme of environmental upgrades, refurbishment and redecoration to provide a safe and therapeutic care.

Organisational Learning from Internal and External Reviews

One of the Trust's 2012-13 quality priorities was to deliver safe services by demonstrating learning from internal and external reviews. In Quarter 1 the Trust's Report and Learn bulletin was revised. It now shows a clearer link between incidents and the learning. The serious incident section also focuses on a small number of themes or learning in order that managers and professional leaders are able to focus on priorities.

In Quarter 2 the Trust committed to ensuring that serious incident reviews were only signed off when confirmation has been received about when, and by whom, the review will be fed back. A recent audit of this demonstrated 100 per cent compliance. Throughout 2012-13 all internal reviews have been undertaken by an objective peer with the recognised training to undertake the review. Furthermore, from 2012-13 action plans have been written and owned by the manager responsible for the service. This ensures that from the construction of the action plan, actions are locally owned and delivered. The Trust holds a central risk register of all open actions and maintains a log of progress made.

In 2013-14 one of the Trust's priorities for improvement was to review and revise the serious incident review process. The Nurse Consultant for Patient Safety worked closely with the Executive Director of Nursing and Quality to ensure national best practice was reflected in the local incident review process.

The Trust also committed to implement the Medical Early Warning Signs (MEWS) model for full roll out by January 2014. Each inpatient service submitted a training implementation plan by the end of Quarter 1 2013-14 with at least 50 per cent of staff trained by Quarter 2. In

Quarter 3 each inpatient ward hit a minimum of 85 per cent compliance with training enabling them to roll out the model.

Clinical Leadership and Governance Structures
The Trust has recently re-developed its clinical leadership and governance structures. Full details can be found at:
http://staff.sussexpartnership.nhs.uk/staff/corporate/comms/wmb/?assetdetesctl6829718=391773.

The Trust states:
"This new structure aims to reduce bureaucracy and improve clinical engagement through a flatter structure with distributed leadership, and greater involvement in decision-making. The interactive network model is a framework for effective working, there is, of course, no substitute for good leadership or getting the right people on the right tasks. The management restructure, intends to do just that, and the changes outlined in this paper will be underpinned by a robust programme designed to provide leaders for the future and develop managerial maturity. To this end, we will be reviewing in-house programmes designed for managers and providing a more integrated and focused approach to development and talent management.

This structure provides an opportunity for senior clinicians to step up and become much more involved in leading the organisation. This is a big ask as the future will be challenging, to meet the challenge of improving quality, productivity and efficiency we need to work differently, be less centrally driven and more customer-focused. However, this is a new way of working, getting it right involves full commitment to our strategic aims, a robust grip on the detail, and a willingness to work vertically and horizontally to deliver…

… The divisional structures are based on matching local and clinical need, achieving best fit in terms of service clusters. This is in keeping with the overarching guiding principle that 'form should follow function'. In core divisions we need to embrace consistency and promote best practice, while we develop effective relationships with clinical commissioning groups (CCGs).

Specialist divisions have various commissioning arrangements in and beyond Sussex as services grow and funding is less reliant on block contracts. The inclusion of Kent and Medway within the Children and Young Peoples' Division (CYPD) requires a purpose-built governance structure to support the scale and geographical spread of this new service. In the Adult Specialist Division (ASD) services are diverse and there is a need to use the synergies between care pathways and focus on our aim to lead the way in this field.

While recognising the inherent differences, clinical leadership structures are based on the same principles and designed by division...

… The Senior Clinical Director post

To ensure consistency and maximise learning in core services a new role is being introduced; the senior clinical director (SCD). There are three of these posts and their role is to bring a mixed clinical perspective to strategic planning for care groups trust- wide. Each represents a different component of service, and together they represent the journey from primary to secondary care, care clusters and care pathways. Their experience of clinical leadership within the organisation provides the stability going forward with this more ambitious organisational structure. They are accountable to the chief operating officer and will work in partnership with a service director to:

- *develop divisional clinical leadership*
- *identify the context for change*
- *facilitate transformation through innovation and improvement*
- *ensure patient safety*
- *critically evaluate services*

It is envisaged the SCDs will spend less time on operational management than they did in their clinical director role, this is because the structure seeks to embed decision-making closer to the frontline, supported by an approach to workforce planning processes which will aim to coordinate skills and special interests in a way that is more beneficial. Post holders will be supported through training and personal development and will have clarity of role to prevent upward delegation. This principle applies across all operational services.

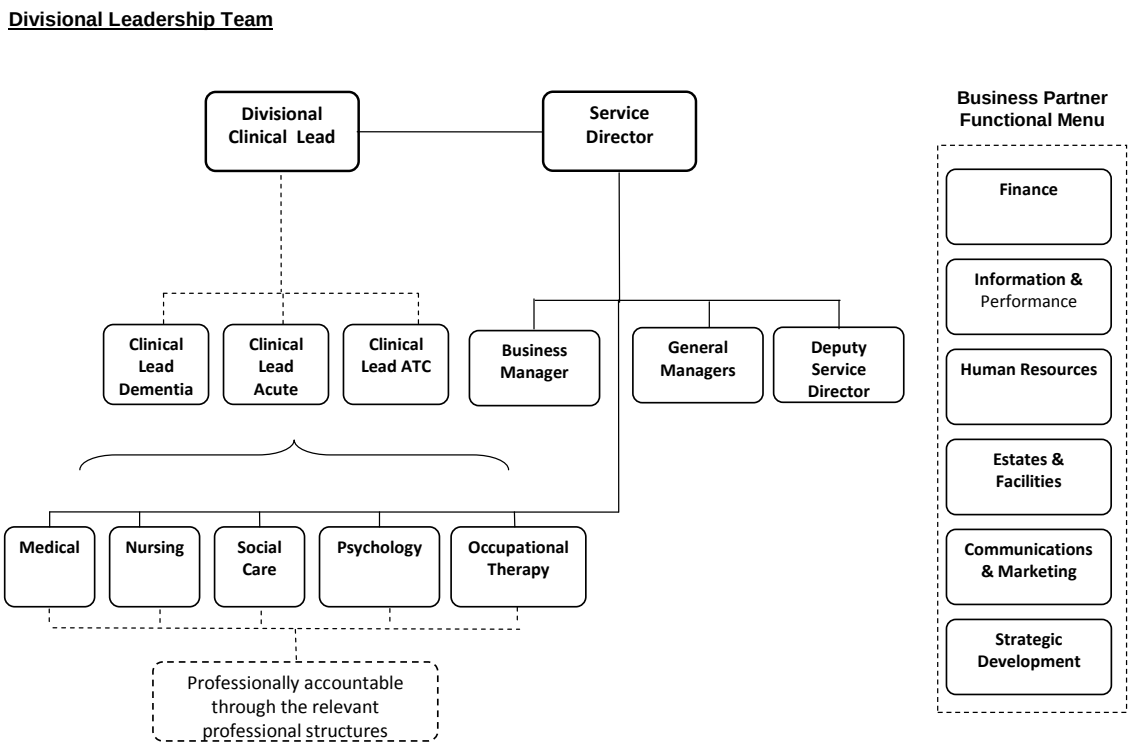
The Divisional Clinical Lead Post

The DLT will be chaired by the divisional clinical lead (DCL), a new post. This role, unlike the SCDs, is not care group specific, and the post holder is accountable to and jointly responsible with the service director for the integrated services within the division. The DCL will be professionally accountable to an appropriate SCD or senior professional within the relevant professional structure.

Reporting to the divisional clinical lead, will be clinical leads, each of whom will take on the responsibility for a functional service area, (i.e. Acute Care, ATCs, etc) in partnership with a general manager. These clinical leads will report to the divisional clinical lead and be jointly accountable with the general manager for the delivery of their objectives.

The post will be open to applicants from any profession, provided they have experience of professional leadership at a senior level.

The chart below indicates responsibilities and accountability within a DLT in core services."



12.1.11.3. Conclusions

The Independent Investigation Team found the governance structures and processes in place at the Sussex Partnership NHS Foundation Trust to be robust. The new structures are in the process of being embedded and will be subject to monitoring and review by the Trust Board and local scrutiny and commissioning agencies.

13. Conclusions Regarding the Care and Treatment Mr. Y Received

Care and Treatment

Mr. Y was appropriately admitted as an informal patient following an unsuccessful suicide attempt. Clinical staff could not identify any signs of a mental illness and even though Mr. Y went on to be detained on a Section 5(4) and then a Section 5(2), because he tried to leave the ward, he agreed to be treated as a voluntary patient and appeared to have recovered from his acute distress. Both Mr. Y and his family wanted him to be admitted to The Priory so that he could continue his recovery before returning home and there appeared to be no clinical reason why this should not take place. However the ensuing emphasis upon his transfer seemingly displaced the focus away from the risk that Mr. Y posed to his wife, whether it related to a mental illness or not.

Mr. Y required a more in-depth level of diagnostic formulation and risk assessment than he received. It was known that:

- he had consistent delusions about his wife being unfaithful to him over a 46-year period;
- he had made a serious attempt on his own life as a consequence of being told recently that his wife had not been a virgin at the time he met her;
- he had required detention under the Act;
- he had been voicing his intention to kill his wife in the context of his obsessional thoughts and feelings of intense jealousy;
- his family came forward with a history of his persistent physical violence towards his family;
- his children and wife believed that he was serious in his threat to kill her and felt so afraid that they notified the police.

Mr. Y's Trust-based treating team were concerned and consequently a referral to forensic services was made. However in the absence of a coherent diagnostic and risk formulation no robust treatment strategy was developed once the forensic service referral was blocked and Mr. Y's transfer to The Priory was progressed.

Mr. Y's case appeared to have been unusual for two main reasons:

- he wished to be transferred to The Priory and was self funding;
- he was placed within the older adult service, but at only 66 years presented with the problems and risks usually associated with an adult of working age.

The treating team also appeared to have been caught up in a series of contradictions.

1. Mr. Y was initially referred to the Harold Kidd Unit because he was depressed and had attempted suicide, but as time went by he was voicing his intent to kill his wife rather than to take his own life.
2. Mr. Y was charming and articulate, but his family said he was manipulative and dangerous and not to be trusted.

3. Mr. Y needed to be detained under the Act because he wanted to leave the ward but stated that he was happy to stay on the ward as voluntary patient hence obviating the need for full Mental Health Act assessment.
4. Mr. Y wanted to leave Trust-based inpatient services was happy to be admitted to The Priory.

The situation was undoubtedly complex. However a case such as this requires robust formulation and a management strategy. It was evident that a series of processes and systems failed to operate effectively in the care and treatment of Mr. Y. These were:

- risk assessment and diagnostic formulation;
- forensic service referral;
- professional communication and transfer liaison;
- family protection procedures and police notification.

Summary

Mr. Y's admission to the Harold Kidd Unit failed to provide an appropriate level of assessment and management in the context of the risk that he presented. The Independent Investigation Team did not however find any causal or contributory factors linked to the deaths of Mr. and Mrs. Y and any acts or omissions on the part of the NHS Trust. Mr. Y's care and treatment continued after his discharge from the Harold Kidd Unit and there was opportunity for assessment and clinical management processes to be developed further, this means that any acts or omissions on the part of the NHS Trust did not in themselves lead to a situation that could not have been mitigated against within the interval of time between Mr. Y's discharge and the deaths of both him and his wife.

Regrettably the deaths of Mr. and Mrs. Y were predictable. Mr. Y stated clearly his intentions to kill his wife. It is unusual for a perpetrator of homicide to be so explicit about their plans; consequently once stated such threats should always be taken seriously. However it is not a straight forward task to determine how, or if, the tragedy could have been prevented. In order for something to be preventable it has to be assumed that clinicians and treating teams have:

- the knowledge;
- the opportunity;
- the legal means.

In the case of Mr. Y it was evident that he had made plans to kill both himself and his wife and had shared these plans with his wife and Consultant Psychiatrist 1. Even though he went on to deny he would follow these though, his treating team had the knowledge and his family had no doubts that his threats would be realised.

Mr. Y was an inpatient on the Harold Kidd Unit for eleven days; his treating team therefore had the opportunity to assess him and develop a suitable clinical management approach.

The difficulty however rests with the legal means available to his treating team. No active mental illness could be detected. This meant that detention under the Mental Health Act if

Mr. Y decided to discharge himself would not have been possible. This was the reason the referral to the forensic service was made so that Mr. Y could receive a specialist assessment to determine his level of dangerousness and whether he met the criteria for detention under the Act. It cannot be known what the forensic service would have advised had they met with Mr. Y in December 2007 or if any mental illness or disorder would have been identified. Based upon the clinical judgement of Consultant Psychiatrist 1, who met with Mr. Y on several occasions, no mental illness was present and therefore there were no legal means to intervene. That being the case, in the absence of any other specialist intervention being available within the short window of time needed, the treating team had no choice but to acquiesce to Mr. Y's decision to be transferred to The Priory. The Independent Investigation concluded that at the point of discharge there were no legal means to detain Mr. Y based upon the clinical assessments that had been conducted to date.

At the point of Mr. Y's discharge from the Harold Kidd Unit the police had been notified by the family of his threats to kill his wife and shortly after Mr. Y's admission to The Priory the team there also became aware of the nature of these threats. Whilst the Independent Investigation Team concluded that the NHS Trust treating team should have been more proactive and sought to communicate and liaise with both the police and The Priory it cannot be known how either of these other stakeholders would have reacted or would go on to manage the case. The Independent Investigation Team concluded that, whilst the clinical team from the Sussex Partnership NHS Foundation Trust could have managed aspects of the care and treatment of Mr. Y more effectively, it could not have been expected to have prevented the events of 23 December 2007.

14. Sussex Partnership NHS Foundation Trust's Response to the Incident and Internal Review

14.1. The Trust Serious Untoward Incident Process

Initial Reporting of the Incident
The report of the homicide was made on 24 December 2007 and the Strategic Health Authority (SHA) notified.

The 72 Hour Report
An initial report was made with immediate effect. On 28 December 2007 a conference call was held which included representatives from the SHA, Sussex Constabulary, Sussex Partnership Trust and The Priory Hospital group. It was identified that primary care and GP involvement would also have to be included. Two separate investigations ensued, one by the NHS Trust and one by The Priory Hospital. At this meeting it was agreed that the following issues would be considered:

- patient safety;
- sharing of information, including matters of patient confidentially;
- immediate care to relatives, patients, and staff communications;
- action and follow up.

14.2. The Trust Internal Review

The Internal Investigation Review Team comprised the following personnel:
The panel was comprised of:

- the Project Manager for Operational Services;
- the Associate Director for Acute Services in Brighton.

The Terms of Reference
There appear to have been no formal terms of reference set.

Methodology
A root Cause Analysis methodology was used. The review comprised a documentary analysis of the clinical records only, no interviews took place and no witness statements were taken. The internal investigation panel members acknowledge that whilst this was not unusual practice in the Trust at the time investigations are managed very differently today.

Key Findings
The Root Cause Analysis found that:

1. **Patient Factors:** the working diagnosis (taken from The Priory notes) was Adjustment Disorder in respect of Mr. Y's reaction to Mrs. Y's previous sexual

activity with a degree of pathological jealousy and a narcissistic style to his personality. Mr. Y also had a self-reported history of obsessional thoughts about his wife's pre-marital sexual relationships.

2. **Individual Factors:** Mr. Y was a 66-year old man, therefore admitted to an older people's service, however his clinical needs may have been better met in an adults' of working age service.
3. **Task Factors:** on the whole staff had the skills and abilities to carry out planned tasks effectively. There were clear signs of planning and the implementation of those plans. It was also noted that observation and therapeutic engagement good practice was followed.
4. **Communication Factors:** communications with forensic services were not direct but via administrative staff. The culture of liaison with police regarding possible offending behaviour was not embedded in ward practice.
5. **Team and Social Factors:** there was clear evidence of good team working such as the seeking of opinion, and the sharing of information and concerns. There was clear leadership demonstrated by the Ward Manager and Consultant. However the Single Assessment Process (SAP) Specialist and Comprehensive Tool was not used to collect and collate data, therefore this was found scattered throughout the clinical record.
6. **Organisational and Strategic Factors:** assessment of potential for violence and aggression was not developed to any extent by older people's services. There was an apparent lack of system response to urgent forensic referrals despite lessons for learning from a previous Serious Untoward Incident. No system was in place to instigate liaison with the police with regard to patients who may be exhibiting offending behaviours on older people's units.

No root causes or contributory factors were found, however the following influencing factors were identified:

- apparent lack of system for response to urgent forensic referrals despite recommendations from an earlier serious untoward incident report;
- no system in place to instigate liaison with the police with regard to patients who may be exhibiting offending behaviours on older people's units;
- the Single Assessment Process (SAP) was not used;
- assessment of potential violence and aggression was not developed to any extent in older people's services.

Internal Review Team Analysis and Conclusions

The internal investigation concluded that:

- Mr. Y had been admitted into hospital appropriately following the suicide attempt made at his home. During Mr. Y's admission to the Harold Kidd Unit his family alerted clinical staff to his stated plan to kill his wife and then kill himself during his admission;
- reassessment enabled Mr. Y to state that risk to his wife and himself had diminished;

- a referral was made to the forensic service by the Consultant Psychiatrist but to *"no avail";*
- Mr. Y was transferred at his request to a private hospital from where he was discharged;
- whilst the internal investigation did not demonstrate any clear root causes to the incident it does raise a number of recommendations for improvements to the delivery of services.

Table Two: Findings, Recommendations and Actions

Findings	Recommendations	Actions
Apparent lack of system for response to urgent forensic referrals despite recommendations from SUI No 83	Forensic service to review recommendations previously made and put into action the system for responding to urgent referrals	
No system in place to instigate liaison with regard to patients who may be exhibiting offending behaviours on Older People's Mental Health (OPMH) units	Trust wide guidance to be developed in liaison with Sussex police to support staff in managing incidents where it is possible an offence has taken place	
SAP specialist and comprehensive assessment tool not used to collect/collate data therefore found scattered throughout the record	Single Assessment Process Older People's Mental Health West Sussex guidance to be reviewed	SAP OPMH lead to work with in-patient unit staff to review guidance supporting the SAP and to link with the OPMH Clinical Nurse Specialist's review of in-patient assessment paperwork
Assessment of potential violence and aggression not developed to any extent in OPMH services	SAP OPMH West Sussex assessment tools to be reviewed /developed to fulfil requirements for the assessment of potential violence and aggression	SAP OPMH lead to develop further OPMH assessment tools (to include the assessment of potential for violence and aggression) in conjunction with advice from other care groups.

Independent Investigation Team Feedback on the Internal Investigation Report Findings

The Independent Investigation Team concurred with the view of the Trust in that the Janaury 2008 internal investigation, whilst identifying useful lessons for learning and instigating service devolvement, should have been managed differently. All current serious untoward incident investigations hold targeted interviews with witnesses and are no longer conducted as desk top reviews. All witnesses involved in current cases receive direct feedback of the findings and are supported to learn any lessons pertinent to their individual practice.

14.3. Being Open

The National Patient Safety Agency issued the *Being Open* guidance in September 2005. All NHS Trusts were expected to have an action plan in place regarding this guidance by 30 November 2005, and NHS Trusts were expected to have their action plans implemented and a local *Being Open* policy in place by June 2006. The *Being Open* safer practice notice is consistent with previous recommendations put forward by other agencies. These include the NHS Litigation Authority (NHSLA) litigation circular (2002) and Welsh Risk Pool technical note 23/2001. Both of these circulars encouraged healthcare staff to apologise to patients and/or their carers who had been harmed as a result of their healthcare treatment. The *Being Open* guidance ensures those patients and their families:

- are told about the patient safety incidents which affect them;
- receive acknowledgement of the distress that the patient safety incident caused;
- receive a sincere and compassionate statement of regret for the distress that they are experiencing;
- receive a factual explanation of what happened;
- receive a clear statement of what is going to happen from then onwards;
- receive a plan about what can be done medically to repair or redress the harm done.

Although the *Being Open* guidance focuses specifically on the experience of patients and their carers it is entirely transferable when considering any harm that may also have occurred to members of the public resulting from a potential healthcare failure.

In Janaury 2008 the Trust wrote to Mr. and Mrs. Y's three children to inform them that an internal investigation was taking place *"into the tragic incidents of 24 December 2007."*

On 28 April 2008 the Trust wrote to one of Mr. and Mrs. Y's daughters in response to a letter sent by her on 4 April raising concerns. The Trust pointed out that it did not usually share internal investigation reports. The letter however detailed the investigation findings to-date

and gave an assurance that the family's concerns would be examined in due course. A meeting with the family was offered by the Trust Chief Executive.

On 28 August 2008 the Trust wrote again to say that the internal investigation was complete and lessons for learning had been identified. It does not appear that the internal investigation report was shared with them. The Independent Investigation Team acknowledges that a detailed letter was sent and a meeting offered, however it would have been better practice had the full report been shared in a timely manner.

14.4. Staff Support

The Independent Investigation Team was only able to interview one member of the clinical team involved in the care and treatment of Mr. Y. This individual did not feel unsupported but found the Inquest and Investigation processes daunting. A lesson for learning for the Trust is to ensure that all staff are provided with robust support and advice. The Independent Investigation Team acknowledges that this is an old case and that processes within the Trust are different today.

14.5. Progress against the Trust Internal Review Action Plan

As a result of the Trust internal investigation the following has been achieved:

1. A protocol for referrals between Mental Health and Secure and Forensic Services has been developed. This ensures that referrers to the service understand what responses should be and to resolve any difficulties that may occur. Disagreements and persistent difficulties are now resolved at Clinical Director level.
2. There has been an increase in the number of secure and forensic practitioners and services are now co-located with mainstream mental health services.
3. The Multi-Agency Risk Assessment Conference (MARAC), which is part of a coordinated community response to domestic abuse, is now working well. Trust personnel attend monthly meetings and working relationships with the Police have been developed. The Trust has been able to take several problematic cases through this route. Had Mr. Y been a patient with the service todays concerns would have been channelled via this process.
4. The Trust has developed a memorandum of understanding with local police services. This memorandum defines how communications should be managed and how concerns should be escalated. There is a named police liaison officer identified, the Trust Chief Executive has regular meetings with senior officers and there is also an annual conference to ensure that joint practice is examined.
5. The Trust has developed a stand-alone risk policy which provides additional guidance to that previously offered by the CPA policy. Significant work has been undertaken to develop risk tools and all services are required to use the Trust comprehensive risk assessment; secure and forensic services may also use the HCR-20. This means that

each service user has risk assessed in a comprehensive manner. This implementation has been supported by a comprehensive training programme and compliance audit process.

6. Services managed by the Trust today are 'ageless' in that each service user is directed according to diagnostic need rather than by age. Had Mr. Y been a patient with the Trust today he would most likely have been admitted to an adults of working age facility which would have been better placed to assess him and would have provided a more appropriate clinical environment.

7. A great deal of work has been undertaken to ensure lessons are learned from serious untoward incidents. There are several processes currently in place that allow the Trust to learn from these incidents. Usually there is an immediate debriefing of the whole team and then often a later debriefing as well, sometimes with a facilitator who is usually a psychologist. In terms of the medical staff the Trust has been encouraging people to use their Continuing Professional Development groups to discuss any serious incidents and also to present cases as a case conference in a multidisciplinary setting.

15. Notable Practice

During the course of the Independent Investigation four main points of notable practice were identified.

The Independent Investigation Team also found that the 'Under One Roof' (U1R) modernisation process of Sussex Partnership NHS Foundation Trust to be a notable service modernisation initiative. The reader is invited to contact the Trust directly to discover more about this approach to managing and delivering secondary care mental health services. A summary of the service is set out below.

"Key elements of the new model
The U1R model for community mental health services provides an ageless, needs-led service for adult population suffering with complex mental health conditions that require specialist help/interventions (previously served separately by WAMHS & OPMHS). It is designed to be lean and efficient, providing quick response with comprehensive assessments by our most skilled professionals followed by evidence based treatments with emphasis on recovery and independent living. The model will ensure less need for re-assessments and transition between teams and care will follow clear treatment pathways with periodic monitoring of progress to enable/achieve desired clinical outcomes. The model is based on recovery and personalization principles and will facilitate through-put through the system; it is designed to better patient engagement and compliance as well as enhancing their experience and quality of life.

The U1R model sits on the foundations of a robust primary care service which has been/is being designed around local communities to provide advice and interventions for people with mild to moderate mental health issues. The primary care service (i.e. Health in Mind in East Sussex) is also tasked with managing demand by building capacity in primary care medical services and working across with other partner agencies.
The U1R model has assessment and treatment components which will be served by appropriately skilled professionals drawn from a large pool of skill-mix. The required workforce/skill-mix will be brought together by removing the bureaucratic boundaries that have existed between care groups in our mental health delivery system. As part of the U1R model the roles, responsibilities and expertise of all professionals working in the system will be clearly defined and their skills effectively and efficiently deployed to the needs of service users. Following a comprehensive initial assessment where the diagnosis, case formulation with prognosis and a management plan will be drawn out, treatment will broadly follow one of two lines, i.e. short-term treatment and discharge or longer term care management for the more complex and high risk cases which require a slower recovery approach. However irrespective of the course through the system all patients will be provided treatment as per designated evidence-based treatment pathways with regular periodic monitoring of agreed outcome goals.

U1R services will be provided from one (or occasionally two) centre(s) called the "Assessment and Treatment Centres" in each locality. These A&T Centres will act as the main point of entry and service provision for all our adult service users and as such lessen the confusion that has hitherto existed in negotiating appropriate care by their referrers. Besides the economies of scale of a large pool of professionals working together and the wealth of experience and expertise that they bring should provide confidence and stability in the workforce to take on the challenges of care provision with less reliance on hospital beds. The model is envisaged to increase productivity, reduce unnecessary waste and be user and referral friendly."

16. Lessons for Learning

First Lesson: Comprehensive risk assessments should always be conducted following an attempted suicide or when a service user makes a declaration of intent to harm or kill another person. This is basic good practice. In a case such as Mr. Y's when personality issues of long standing exist combined with significant concerns raised by family members, then mental health services have a responsibility to consider triggering a multi-agency alert. It was evident that in this case mental health services within the NHS Trust did not know how to react to Mr. Y and the default position, was in effect, to do nothing once no mental illness could be detected. Clear protocols are required that provide guidance to staff and to carers.

Second Lesson: Mr. Y was able to manipulate his treating team into not detaining him under a section of the Mental Health Act by staying as a voluntary patient and by claiming his plans to kill both his wife and himself were a mere fantasy. It is a lesson for learning that when a service user presents in a contradictory manner, for example with high levels of distress, a serious suicide attempt and making threats to kill, some scepticism is merited when they suddenly present in an entirely different manner as Mr. Y did literally within a matter of hours. Working to meet the wishes of a service user is not the same thing as ensuring that their treatment needs are met based on a comprehensive assessment.

Third Lesson: It has been a finding of numerous HSG (94) 27 investigations that significant risks manifest when transferring service users from one service to another. When Mr. Y was transferred from the NHS Trust to The Priory there was a significant loss of knowledge and understanding about his case and family situation. Services must ensure that there is a comprehensive handover of all service users who have presented with significant risk. In the case of Mr. Y this was not achieved and this left his wife and other family members in the position where they had to establish new relationships with new services. During this transition period the family were unable to establish a relationship with the new treating team and Mr. Y's perspective of his situation was allowed to hold sway. This was to the detriment of Mrs. Y's continued safety.

17. Recommendations

The purpose of developing recommendations is to ensure that lessons are not only learned, but influence directly the development and management of services to ensure future patient and public safety.

The Independent Investigation Team worked with the Sussex Partnership NHS Foundation Trust to formulate the recommendations arising from this inquiry process. This has served the purpose of ensuring that current progress, development and good practice have been identified. The recommendations set out below have not been made simply because recommendations are required, but in order to ensure that they can improve further services and consolidate the learning from this inquiry process.

The Executive Directors of the Sussex Partnership NHS Foundation Trust had the opportunity to review the recommendations required for this case at both the preliminary feedback stage and during the factual accuracy checking stage. The Trust should be given recognition for the work that it has put into this process and the progress that it has already made. The HASCAS Independent Investigation Team recognises the fact that an interval of six years has passed since the time of the deaths of Mr. and Mrs. Y and the writing of this report. It is evident that Sussex-based services have changed significantly during this time and the recommendations have been set with this in mind.

17.1. Diagnosis

- ***Service Issue One. The lack of diagnostic formulation meant that an incomplete picture of Mr. Y emerged which was based largely on his own unreliable account. During this period the Trust did not require older people's services to develop a formulation as part of an ongoing risk assessment process and in the case of Mr. Y this served to minimise the degree of risk that he presented.***

Recommendation One
The Trust will ensure that all clinical policies and procedures are amended to instruct clinicians of the importance of providing a differential diagnosis where indicated as clinically appropriate. These amendments will also include instructions as to the importance of providing a clear formulation and the guidance for doing so.

17.2. Risk/Clinical Assessment

- ***Service Issue Two. Poor Trust risk assessment and management systems meant that Mr. Y did not receive a robust risk assessment in the context of his diagnostic formulation. This meant that his levels of risk were neither identified nor managed***

sufficiently whilst at the NHS Trust, and communication was not managed appropriately at the point of his transfer to The Priory.

- ***Service Issue Three. Trust procedures regarding communication with the police were unclear and under developed and could not ensure that the concerns about Mr. Y that were made known to the NHS were passed on and managed in an appropriate and timely manner (please recommendations under section 17.3. below).***

Progress made by the Trust to-date

The Trust has developed a stand-alone risk policy which provides additional guidance to that previously offered by the CPA policy. Significant work has been undertaken to develop risk tools and all services are required to use the Trust comprehensive risk assessment; secure and forensic services may also use the HCR-20. This means that each service user has risk assessed in a comprehensive manner. This implementation has been supported by a comprehensive training programme and compliance audit process.

Recommendation Two

The Trust will conduct an audit of its risk assessment processes within six months of the publication of this report to determine:

- **the compliance of all clinicians in the completion of risk assessments for every service user;**
- **the compliance of all clinicians in the development of risk management plans;**
- **the compliance of all clinicians in completing all risk assessment documentation and not using drafts in place of comprehensive records.**

17.3. Referral, Transfer and Discharge Planning

- ***Service Issue Four. At the time Mr. Y received his care and treatment from the Trust all adults above the age of 65 years were placed with the older peoples' service. This occurred regardless of clinical need and presentation. Mr. Y found himself in a facility which could not provide the level of assessment and management that he needed and one which both he and his family found to be inappropriate for him, hence wanting him to be transferred to The Priory.***

- ***Service Issue Five. Referral processes for emergency assessment with forensic services did not operate in a timely manner leaving the NHS Trust Consultant Psychiatrist without access to a specialist second opinion.***

- ***Service Issue Six. The transfer process between the NHS Trust and The Priory was not managed well in that professional communication was limited and no copy of Mr. Y's clinical records were sent. This meant that an incomplete picture of Mr Y was given and continuity lost.***

Progress made by the Trust to-date

A protocol for referrals between Mental Health and Secure and Forensic Services has been developed. This ensures that referrers to the service understand what responses should be and to resolve any difficulties that may occur. Disagreements and persistent difficulties are now resolved at Clinical Director level.

There has been an increase in the number of secure and forensic practitioners and services are now co-located with mainstream mental health services.

Services managed by the Trust today are 'ageless' in that each service user is directed according to diagnostic need rather than by age. Had Mr. Y been a patient with the Trust today he would most likely have been admitted to an adults of working age facility which would have been better placed to assess him and would have provided a more appropriate clinical environment.

Recommendation Three

The Trust will conduct an audit to ascertain the effectiveness of its new arrangements. These audits should be conducted within six months of the publication of this report and be developed in collaboration with commissioners. The Trust should:

- **audit all referrals made to the forensic service over the past 18 months to ascertain service response against the new protocol;**
- **review all complaints about accessing forensic services with a particular focus on those referred to Clinical Director level;**
- **ascertain the success of the 'ageless' service approach by surveying service users and consulting with primary care.**

17.4 Documentation and Professional Communication

- ***Service Issue Seven. During the period in which Mr. Y received his care and treatment from the NHS Trust there were no protocols in place to inform practitioners how best to liaise with the both the police and the private sector in relation to reporting ongoing concerns about the service users in its care. This served to prevent important information about Mr. Y from being shared in a timely manner with services which could have ensured further assessment was made and the necessary management plans put into place.***

Progress made by the Trust to-date

The Multi-Agency Risk Assessment Conference (MARAC), which is part of a coordinated community response to domestic abuse, is now working well. Trust personnel attend monthly meetings and working relationships with the Police have been developed. The Trust has been able to take several problematic cases through this route. Had Mr. Y been a patient with the service todays concerns would have been channelled via this process.

The Trust has developed a memorandum of understanding with local police services. This memorandum defines how communications should be managed and how concerns should be escalated. There is a named police liaison officer identified, the Trust Chief Executive has regular meetings with senior officers and there is also an annual conference to ensure that joint practice is examined.

Recommendation Four
The Trust should audit all new processes for effectiveness within six months of the publication of this report. The audit should ensure that Trust personnel attend MARAC meetings on a regular basis and should also serve to review how many cases have been referred to the police by the Trust and the consequent outcomes and lessons for learning.

17.5. Adherence to Local and National Policy and Procedure

- ***Service Issue Eight. The Trust did not have in place sufficiently robust evidence-based policy guidance to direct clinical staff. This impacted upon the quality of the risk assessment that Mr. Y received and upon communication and liaison processes with the police and The Priory.***

Progress made by the Trust to-date
The Trust has made significant progress to-date to ensure that new policies and procedures have been developed and are in place to provide guidance to clinical staff. The monitoring of their efficiency will be undertaken by the implementation of the recommendations set out above.

17.6. Other Progress made by the Trust To-date

A great deal of work has been undertaken to ensure lessons are learned from serious untoward incidents. There are several processes currently in place that allow the Trust to learn from these incidents. Usually there is an immediate debriefing of the whole team and then often a later debriefing as well, sometimes with a facilitator who is usually a psychologist. In terms of the medical staff the Trust has been encouraging people to use their Continuing Professional Development groups to discuss any serious incidents and also to present cases as a case conference in a multidisciplinary setting.

18. Glossary

Care Coordinator	This person is usually a health or social care professional who coordinates the different elements of a service user's care and treatment plan when working with the Care Programme Approach.
Care Programme Approach (CPA)	National systematic process to ensure assessment and care planning occur in a timely and user centred manner.
Care Quality Commission	The Care Quality Commission is a non-departmental public body of the United Kingdom government established in 2009 to regulate and inspect health and social care services in England. This includes services provided by the NHS, local authorities, private companies and voluntary organisations - whether in hospitals, care homes or people's own homes.
Care Coordination	The process within the Trust where a patient is allocated to a Care Coordinator who is based within a Community Mental Health Team.
Clinical Negligence Scheme for Trusts	A scheme whereby NHS Trusts are assessed. It provides indemnity cover for NHS bodies in England who are members of the scheme against clinical negligence claims made by, or in relation to, NHS patients treated by or on behalf of those NHS bodies.
Mental Health Act (1983 and 2007)	The Mental Health Act 1983/2007 covers the assessment, treatment and rights of people with a mental health condition.
Named Nurse	The 'Named Nurse' is a nurse designated as being responsible for a patient's nursing care during a hospital stay and who is identified by name as such to the patient. The concept of the named nurse stresses the importance of continuity of care.
National Patient Safety Agency	The National Patient Safety Agency leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector. This is in part achieved by the publication of best practice guidelines.

Primary Care Trust	An NHS Primary Care Trust (PCT) is a type of NHS Trust, part of the National Health Service in England, that provides some primary and community services or commissions them from other providers, and is involved in commissioning secondary care, such as services provided by Mental Health Trusts.
PRN	The term "PRN" is a shortened form of the Latin phrase *pro re nata*, which translates roughly as "as the thing is needed". PRN, therefore, means a medication that should be taken only as needed.
Psychotic	Psychosis is a loss of contact with reality, usually including false ideas about what is taking place.
Risk assessment	An assessment that systematically details a person's risk to both themselves and to others.
RMO (Responsible Medical Officer)	The role of the RMO is defined in law by the Mental Health Act (1983) referring to patients receiving compulsory treatment.
Service User	The term of choice of individuals who receive mental health services when describing themselves.
SHO (Senior House Officer)	A grade of junior doctor between House Officer and Specialist Registrar in the United Kingdom.
Specialist Registrar	A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.
Staff Grade Doctor	In the United Kingdom, a staff grade doctor is one who is appointed to a permanent position as a middle grade doctor.