VERITA

IMPROVEMENT THROUGH INVESTIGATION

An investigation into the care and treatment of Mr A

A report for NHS Yorkshire and the Humber

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Author:
Sue Bos

Peer reviewer:
Chris Brougham

Verita is an independent consultancy that specialises in conducting and managing investigations, reviews and inquiries for public sector and statutory organisations.

Verita
53 Frith St
London W1D 4SN

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website www.verita.net

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1. Introduction

1.1 NHS Yorkshire and the Humber commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service user, following his conviction for murder.

1.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

1.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it will usually find things that could have been done better.

1.4 We could not identify a critical single cause that led to the outcome in this case but we have identified concerns about processes and systems in the mental health service at the time, which are discussed further in the main report.

1.5 Although we found no causal link between these concerns and the tragedy of 2009, substantial improvements have since been introduced as part of a robust action plan drawn up by North East Lincolnshire Care Trust Plus. The service is now provided by NAViGO, a community interest company.

1.6 We have made recommendations for NAViGO as the new provider of mental health services. These recommendations do not relate to failings on the part of NAViGO, who were not responsible for the service at the time. The recommendations are intended to look into the future in the light of lessons learned from this case.

Background to the incident

1.7 Mr A, a 53-year-old man, stabbed Miss B, a pregnant 21-year-old woman, in 2009, killing her and her unborn child. Mr A pleaded guilty to manslaughter on the grounds of diminished responsibility. However, he was convicted of murder in 2010 and sentenced to life imprisonment with a minimum of 20 years.

1.8 Mr A had been a patient of the mental health service provided by the North East Lincolnshire Care Trust Plus (the CTP).

1.9 Ten and a half months passed between Mr A's last contact with the mental health service and the death of Miss B and her unborn child. The last opportunity for the mental health service to see Mr A was at an outpatient appointment just under six months before the incident. Mr A was out of contact with the service by this time but was never formally discharged.

1.10 The CTP carried out an internal investigation into Mr A's care and treatment shortly after the incident.

Overview of the organisation

1.11 The CTP provided mental health services in North East Lincolnshire at the time of Mr A's care and treatment. It has the legal form of a primary care trust. The CTP is a combined health and social care organisation which both commissioned and provided services, including adult mental health services. In April 2011 mental health services within the CTP transferred to NAViGO, a community interest company (social enterprise). The CTP now commissions NAViGO to provide health and social care mental health services.

2. Terms of reference

2.1 The terms of reference for this independent investigation were set by Yorkshire and the Humber Strategic Health Authority (the SHA) in consultation with North East Lincolnshire Care Trust Plus and the independent investigation team from Verita. The terms of reference are:

To investigate primarily by documentary review:

- the care and treatment the service user had received from the NHS and was receiving at the time of the incident and the suitability of that care and treatment in view of the service user's physical and mental health

- the extent to which that care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health, at that time and how local operational policies and practices addressed such guidance, with particular reference to:

    - risk management
    - records management
    - internal referral policies and procedures
    - discharge policy and post-discharge follow-up

- the interface, communication and joint working between all those involved in assessing the service user and in providing care to meet his mental health, physical health and social needs, including the police and his GP.

To comment upon:

- the conduct and quality of the internal investigation, its ability to identify root causes and the clarity in which these are presented in the internal report

- the strength of the recommendations in the internal report and

- the quality of the action plan, and the subsequent activities of the Care Trust Plus to effectively implement that plan and the evidence of the audit and review of those actions.

To identify:

- aspects of the service user's treatment and management which was of good quality or commendable practice

- learning points for improving systems and services;

- any significant areas for further review.

To produce:

- realistic recommendations for action to address the learning points identified

- a final report that complies with all relevant legislation to enable the publication of the report and recommendations by Yorkshire and the Humber Strategic Health Authority through the Independent Investigations Committee.

Note:

These terms of reference may be subject to change following consultation with key stakeholders and in the event that other significant issues about the care and treatment of the service user and the services being reviewed are identified during the course of the investigation. Any such issue will be brought to the attention of the SHA by the independent investigation team.[1]

2.2 Verita was also commissioned by the SHA to consider a number of issues raised by a psychologist who was employed by the CTP at the time of Mr A's care and treatment. The investigation team has considered and commented in this report on the issues raised by the psychologist that were relevant to the care and treatment of Mr A and to the CTP's internal investigation. We received evidence on some issues which, in our view, were linked to but not directly relevant to the care and treatment of Mr A. We have considered

[1] This note was included when the terms of reference were finalised by the SHA.

these issues carefully. Other matters raised by the psychologist that were outside the terms of reference were shared with the SHA, but we did not feel there was a need for further investigation or for any alteration to the scope of this investigation. We have referred to the psychologist as psychologist 2 in this report.

3. Executive summary and recommendations

Introduction

3.1 NHS Yorkshire and the Humber commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service user, following his conviction for murder.

3.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of the main report.

3.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it will usually find things that could have been done better.

3.4 We could not identify a critical single cause that led to the outcome in this case but we have identified concerns about processes and systems in the mental health service at the time, which are discussed further in the main report.

3.5 Although we found no causal link between these concerns and the tragedy of 2009, substantial improvements have since been introduced as part of a robust action plan drawn up by North East Lincolnshire Care Trust Plus (the CTP). The service is now provided by NAViGO, a community interest company.

3.6 We have made recommendations for NAViGO as the new provider of mental health services. These recommendations do not relate to failings on the part of NAViGO, who were not responsible for the service at the time. The recommendations are intended to look into the future in the light of lessons learned from this case.

Background to the incident

3.7 Mr A, a 53-year-old man, stabbed Miss B, a pregnant 21-year-old woman, in 2009, killing her and her unborn child. Mr A pleaded guilty to manslaughter on the grounds of diminished responsibility. However, he was convicted of murder in 2010 and sentenced to life imprisonment with a minimum of 20 years.

3.8 Ten and a half months passed between Mr A's last contact with the mental health service and the death of Miss B and her unborn child. The last opportunity for the mental health service to see Mr A was at an outpatient appointment just under six months before the incident. Mr A was out of contact with the service by this time but was never formally discharged.

Diagnosis and treatment

3.9 Mr A was admitted twice to a mental health ward after twice walking into a police station carrying a knife and saying he was hearing voices telling him to kill someone. Mr A presented the mental health service with a complicated picture of self-reported hallucinations, documented heavy use of alcohol and possible brain damage. The multidisciplinary team (MDT) requested appropriate investigations but missed some opportunities for clarification and consultation during Mr A's admissions. The various elements of his assessment and treatment did not appear to have been considered as a whole, or discussed within the MDT. The mental health service lost touch with Mr A when he was discharged from hospital, although attempts were made to contact him for outpatient appointments.

Risk management

3.10 Mr A was consistently calm and pleasant when he was in hospital, with no history of violence, but there were factors suggesting a higher level of risk than the MDT perceived. Risk assessment did not take some significant elements into account. It was reasonable to discharge Mr A from hospital, but he should have been monitored in the community with a better understanding of the risk he might pose to the public.

3.11 NAViGO has enhanced the risk management processes and the service has had a reputation for good practice in the provision of training and a high quality environment for several years. Acute mental health services are now provided in purpose built accommodation with a new model of acute care.

Records management

3.12 The standard of Mr A's paper records was generally good but with some significant gaps. For example: the records showed no discussion within the MDT of the uncertainty about Mr A's case; CPA and risk management documentation was incomplete and there was no record of some significant events including a decision to discharge Mr A from the service. Nursing and medical records were on the same pages in the case file but multiple other records systems in use at the time prevented a clear overview of Mr A's care and treatment.

3.13 The benefits of NAViGO's integrated paper and electronic records are already apparent within the service.

Internal referral policies and procedures

3.14 The MDT was diligent in requesting tests and opinions but did not use the outcomes well. Referrals and requests for an opinion on Mr A were considered or made to eight complementary services. Test results were not fully taken into account and there were no reliable records of some of the requests for specialist opinions or of some of the responses. There was no evidence in Mr A's case notes of direct consultation with colleagues in related specialities about the uncertainties of this case.

Psychology service

3.15 The process used to access the psychology service for Mr A was not fit for purpose. We could not establish exactly what happened between the psychology service and the MDT in Mr A's case, despite interviewing staff and examining documentary evidence, but the opportunity for a full psychological assessment was missed. We do not know if this

would have made any difference in the longer term but it would have increased the MDT's understanding of Mr A. The separateness of the psychology service, both perceived and actual, put everyone at a disadvantage.

3.16 Significant structural and procedural changes to the psychology service have since been made.

Alcohol service

3.17 Alcohol was a significant cause of Mr A's psychosocial problems. He might not have engaged with the alcohol service of his own accord but he could have been supported to access the service while he was an inpatient and as part of a coordinated care plan in the community, as he had done with the help of his GP a few years earlier. Drinking probably played an important role in his relatively empty days and a big shift in his situation would have been needed to bring about any real change.

3.18 NAViGO is finalising a policy for accessing drug and alcohol services to ensure clear criteria for mental health service users.

Older people's service

3.19 This was a complex case and it was good practice to seek an assessment by the older people's service, which deals routinely with organic brain problems, but nothing came of the referral. Nothing in the documentary evidence clarified what happened and the people we interviewed could not explain the failure of this request, despite their efforts to find out. However, the aim of the referral was not to access a specialist opinion to assist with diagnosis and management but to transfer Mr A to the older people's CMHT after he had been discharged. This might have been helpful if it had led to longer-term monitoring by a care coordinator but the referral was not pursued.

Discharge policy, care programme approach and post-discharge follow-up

3.20 The discharge and follow-up arrangements for Mr A were inadequate and the CTP lost contact with him. The mental health service should have seen him again to monitor his treatment, his mental state and his risk profile and to encourage him to access the alcohol service and reduce his drinking. We know little about what happened to Mr A after his last contact with the mental health service in July 2008. He was homeless for a while and he then lived in a Salvation Army hostel. His GP thought he was stable in November 2008 and he had moved into his own flat by February 2009. Mr A seemed fine but quieter than usual when he next saw his family.

3.21 Mr A did not receive letters about three outpatient appointments because he had left his previous address. We do not know how long he would have continued to see a psychiatrist if he had attended, especially if his GP was happy to take over his care. We also do not know whether the involvement of a care coordinator would have made any difference. More might have been known about Mr A's mental state, his alcohol consumption and his social situation but it is unlikely that the care coordinator would have continued to see Mr A after his GP felt he was stable and not in need of regular follow-up. It is unfortunate that, before the events of 2009, Mr A did not approach the mental health service or go to a police station, as he did just over a year earlier.

3.22 NAViGO and the CTP have been diligent in implementing robust new procedures for the care programme approach (CPA) and discharge. The CTP would have had a much better chance of staying in touch with Mr A until he was ready for full discharge, if these arrangements had been in place earlier.

Use of the Mental Health Act

3.23 Mr A was assessed three times under section 136 of the Mental Health Act in 2008. On the first two he was admitted to a mental health ward. On the third, less than two weeks after being discharged, he was not. There was no effective system for the section 136 assessors to know he had been discharged so recently or that the CTP had been unable to contact him for his seven-day follow-up. No system existed to tell Mr A's psychiatrists and his GP about the third time he went to a police station with a knife. This meant his risk profile was not reviewed and the opportunity to engage with him again was missed.

3.24 NAViGO has greatly improved the systems for recording and communicating section 136 assessments.

Interface, communication and joint working

3.25 Interface, communication and joint working were poor in several directions. Many systems were not robust and these weaknesses allowed individual failings to influence care and treatment more than they should have done. This also affected the way Mr A was followed up but we do not know if it affected the eventual outcome.

3.26 NAViGO has demonstrated its awareness of the need for improvement by implementing solutions and acknowledging there is more to be done.

Overall conclusions on Mr A's care and treatment

3.27 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. There are usually lessons to be learned.

3.28 We could not identify a critical single cause that led to the outcome in this case but we have identified concerns about processes and systems in the mental health service at the time.

3.29 Mr A was in hospital for a total of five weeks but his assessment was incomplete with the result that his clinical picture remained confusing. There was no clear focus on some important aspects, particularly potential damage to his brain, heavy use of alcohol and psychological and neuropsychological factors. Antipsychotic treatment was started the day after he was admitted to hospital with no evidence it was really needed. His case was not discussed with colleagues from other specialties. We were not sure Mr A's treatment could have had any positive effect on his mental health.

3.30 The MDT appeared to know little about Mr A's personal and social situation but felt he had some insight into his behaviour and found him consistently pleasant and compliant. Mr A was not supported and monitored in the community. Discharge arrangements were

poor and the CTP lost contact with him when he left hospital but he did not tell them he was homeless. He should have been followed up assertively and encouraged to seek help when he needed it, although he never approached the mental health service of his own accord. He killed Miss B and her unborn child ten and a half months after he was last seen by the mental health service. There were elements of Mr A's care and treatment which could have been much better but we cannot say that this tragedy could have been prevented.

3.31 The CTP and then NAViGO introduced important changes to structures and systems in mental health services after the internal investigation and their efforts to make significant improvements are commendable.

3.32 We have identified further learning for the organisation from the investigation of Mr A's care and treatment. Our recommendations address this learning but we found no causal link between the learning points and the events of 2009.

The CTP's internal investigation

3.33 The CTP's overall approach to the internal investigation impressed us but we were concerned about aspects of the interviews. Good practice was not apparent in inviting staff for interview, nor in inviting them to be accompanied, nor in providing information about the overall process. This probably contributed to some of the subsequent difficulties.

3.34 We did not agree with the CTP's conclusions on diagnosis and treatment but we found the internal investigation report remarkably thorough, despite some inconsistencies between the executive summary, the full report and the evidence.

3.35 The CTP's recommendations were soundly based on the findings of the report. The action plan was robust and measurable with clear evidence of implementation.

Overall conclusions of independent investigation

3.36 We saw and heard a great deal of helpful evidence during our investigation. Some of the evidence we received was contradictory, some of it did not fall within our terms of reference and some of our questions could not be answered. We aimed to reach proportionate, appropriate, fair and reasonable conclusions based on the balance of probabilities.

3.37 We concluded that Mr A's assessment by the mental health service was incomplete, his diagnosis was unclear and staff did not really get to know him. He was not followed up assertively when he left hospital but staff did not know where he was living. We identified problems within the organisational processes but we found no causal link between these problems and the tragedy of 2009. Many substantial improvements have since been introduced.

3.38 The CTP's internal investigation process was based on recognised good practice but there were some problems with staff interviews. We did not agree with the CTP's conclusions on diagnosis and treatment but otherwise found the report remarkably thorough. It was followed through with a robust, evidenced action plan.

3.39 We are grateful for the contributions and support of all the people we interviewed, those who provided documentary evidence, those who facilitated our investigation and those who commented on our draft report.

Recommendations

R1 NAViGO should encourage senior clinicians to contact specialists by telephone about the management of actual or suspected physical comorbidity [e.g. organic brain disease], especially where there are abnormal findings, and to document these discussions. [see paragraphs 5.87, 5.88, 8.147]

R2 NAViGO should encourage senior clinicians to reflect on diagnostic uncertainty and discuss complex cases with peers on an informal basis in addition to discussions within the clinical team. Discussions must be documented in clinical records and in minutes of team meetings. [see paragraphs 5.93, 8.151]

R3 NAViGO should ensure consultant psychiatrists either make or countersign a single entry in the clinical records that clarifies the formulation and opinion of the team after pulling together the opinions of different disciplines. This entry should include the rationale for treatment decisions especially when such decisions are controversial or not supported by clinical evidence or are off license. NAViGO should audit this standard. [see paragraphs 5.71, 5.73, 5.81, 5.89]

R4 NAViGO should ensure current operational guidance emphasises the potential benefit of contacting close associates of the service user, even if he has no formally identified carer. [see paragraph 5.86]

R5 NAViGO should ensure psychologists' case loads and job plans are appropriate and reviewed on a regular basis. [see paragraph 8.31, 8.106]

R6 NAViGO should ensure there is a robust system of supervision for clinical staff which does not rely on the supervisee raising their own concerns about individual cases. Supervisors should identify some cases for discussion and ensure that all cases are discussed within an agreed timescale. [see paragraphs 8.70, 8.104]

R7 The CTP should ensure drug and alcohol services are commissioned to provide an appropriate and accessible service for mental health service users, including inpatients, with a clear mechanism to resolve problems between the services. [see paragraphs 8.119, 8.126]

R8 NAViGO should finalise a policy for accessing drug and alcohol services, to ensure there are clear criteria for accepting mental health service users, including inpatients, and to establish a clear route to discuss problems between the services. [see paragraphs 8.119, 8.126]

R9 NAViGO should ensure there are robust systems for adults of working age teams to seek an opinion from the older people's service and for recording the outcome. [see paragraph 8.148]

R10 NAViGO should ensure there are robust links between the inpatient consultants, the home treatment team and the outpatient consultants that allow for consultation and effective handover. [see paragraph 9.29]

R11 NAViGO should audit the accessibility, content and timeliness of the summary of significant information about a service user, including 136 assessments, available on MARACIS[2], to ensure it is available in an emergency and includes appropriate information. [see paragraph 10.17, 10.19]

R12 NAViGO should audit the mechanism for telling consultant psychiatrists and GPs that one of their service users has had a section 136 assessment that did not result in admission, to ensure it is prompt and robust. [see paragraph 10.18, 10.19]

R13 NAViGO should ensure documented clinical supervision of junior doctors takes place and that case based discussion and scrutiny by the consultant of medical records and written communications completed by junior doctors are key tools in workplace based assessment. [see paragraph 11.16]

R14 NAViGO should liaise with the local police service to ensure the process for confirming any informal joint agreements on managing people known to both services is robust. These agreements should be flagged up by information systems when any significant event occurs. This is for people not involved with the forensic service or with any other formal joint process. [see paragraph 11.20]

R15 NAViGO should ensure current policy on the investigation of serious incidents reflects good practice, such as the guidance from the National Patient Safety Agency, particularly for supporting and interviewing staff and including: debriefing; support and counselling; facilitated discussion within the MDT; written information about the purpose and process of the investigation; interview techniques; being accompanied at interview and confirmation of the record of the interview. The policy should include a robust system of dating and version control for serious incident investigation reports and executive summaries. [see paragraphs 13.47, 13.48, 13.58]

R16 NAViGO should ensure all information given to service users by each department about confidentiality and data protection complies with national and local policy and does not conflict with NAViGO's clinical and managerial responsibilities. [see paragraphs 13.17, 13.51]

[2] Electronic records system for mental health services

R17 The CTP should obtain evidence that all actions resulting from the internal investigation have been completed.

4. Approach and structure

Approach of independent investigation

4.1 The investigation team (referred to from now on as 'we') comprised Chris Brougham and Sue Bos, both senior investigators with Verita. Dr Michael Dilley, consultant neuropsychiatrist at the South London and Maudsley NHS Foundation Trust, provided professional psychiatry advice. Biographies for the team appear in appendix C.

4.2 The amendment to the Health Service Guidelines HSG (94) 27 published in June 2005 required an independent investigation to facilitate openness, learning lessons and creating change. We aimed to work within this framework:

- Openness – the investigation should provide an open, transparent, factual and independent account of the circumstances leading up to the incident and relevant associated matters.
- Learning lessons – finding out what has gone wrong and proposing improvements while balancing individual accountability with criticism of organisational systems and processes.
- Creating the circumstances for change and service improvement – making recommendations that help NHS organisations improve and develop in order to offer better services. Creating a climate in which organisations and individuals accept and act on the findings of the report.

4.3 The CTP wrote to Mr A and asked for access to his medical records. He gave his consent in April 2011 and our independent investigation started in June 2011 when we had received all the documentary evidence.

4.4 We carried out the investigation primarily by documentary review, apart from four interviews requested by the SHA. We examined documentary evidence including:

- relevant local policies and procedures
- copies of Mr A's clinical records
- the CTP's internal investigation report
- documents relating to the CTP's internal investigation
- other documentary evidence.

These documents are listed in appendix B.

4.5 A chronology of Mr A's care and treatment appears in appendix A.

4.6 We met the following people at the request of the SHA.

- The consultant psychiatrist responsible for Mr A's inpatient care and treatment (consultant psychiatrist 1).
- The psychologist who saw Mr A (psychologist 1), who no longer works for the CTP.
- The current director of operations, who was assistant director of mental health at the time of Mr A's care and treatment. We refer to him throughout this report as the director of operations.
- The psychologist who was head of department at the time of Mr A's care and treatment (psychologist 2), who no longer works for the CTP.

4.7 We followed established good practice in conducting interviews. We gave interviewees the opportunity to be accompanied by a representative or friend. We gave them the opportunity to comment on the accuracy of their interview transcripts, and where appropriate, on relevant extracts of our draft report.

4.8 We wrote to Miss B's relatives offering to meet them to explain the purpose and process of the investigation. We received no reply so we wrote again offering to share our findings. We received no reply. We respect their wishes not to be involved with this investigation.

4.9 We met Mr A at Rampton Hospital to explain the purpose and process of the independent investigation and we shared the terms of reference with him. We met him again to share our findings.

4.10 We wrote to Mr A's parents offering to meet them to explain the purpose and process of the investigation. We received no reply so we wrote again offering to share our findings and we met them at their home.

4.11 We analysed all the evidence received; we have taken into account the evidence directly relevant to our terms of reference and made independent findings and recommendations to the best of our knowledge and belief.

4.12 We received conflicting statements about several issues and have set out some of these statements as they were given to us. We have not commented on the veracity of each statement but have drawn our conclusions on the balance of probabilities.

Report structure

4.13 We investigated the care and treatment Mr A received from the start of his contact with acute mental health services in June 2008 until the time of his last potential contact in December 2008. We examined the suitability of the care and treatment in view of Mr A's physical and mental health.

4.14 We considered Mr A's care and treatment within these key themes:

- diagnosis and treatment
- risk management
- records management
- internal referral policies and procedures
    - psychology service
    - alcohol service
    - older people's service
- discharge policy, CPA and post-discharge follow-up
- use of Mental Health Act 1983
- interface, communication and joint working.

4.15 The terms of reference also require us to consider how care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health and how local operational policies and practices addressed such guidance. We considered the key themes in relation to the specific policies and guidance set out in the terms of reference and detailed our findings under the relevant heading.

4.16 We have identified aspects of Mr A's treatment and management that were good or commendable practice throughout this report.

4.17 Our comments on the CTP's internal investigation, recommendations and action plan appear in section 13.

4.18 We identified no significant areas for further review other than those in our recommendations.

4.19 Our comments in this report are in bold italics.

5. Diagnosis and treatment

5.1 In this section we outline what we know about Mr A's background and examine his diagnosis and treatment while he was an inpatient with the mental health service. A full chronology is included in appendix A.

Evidence

5.2 Mr A's clinical notes do not tell us much about his background but record that he was born in Northern Ireland in 1955 and moved with his family to the north east of England. He did not enjoy school and left at 15. He was married for 20 years until his divorce and he had two children.

5.3 Mr A's parents told us that Mr A is the second of their four sons. The family moved from Northern Ireland to the north east of England when Mr A was two or three years old. Mr A moved to north east Lincolnshire in 1994 to work with his brother as an electrician's mate and he settled in the area. Mr A told us he had worked as a chef and in various factories. His last job was with a contract cleaning company on a short term contract which finished in the spring of 2008, a couple of months before his first contact with the mental health service.

5.4 In May 2004 Mr A had a stroke in the right side of his brain but was discharged with no residual weakness. The day before the stroke was diagnosed hospital staff suggested he might be suffering from Wernicke's[3] encephalopathy. In January 2007 he was taken to hospital from work with a severe headache but no other diagnosis was made. His clinical notes from these episodes and his GP records documented a history of heavy drinking with no forensic history except for being drunk and disorderly at the age of 18 or 19.

5.5 At the time of Mr A's first mental health admission in June 2008 he was 52 years old and living in a shared house in Cleethorpes with four men with whom he shared domestic tasks. He usually ate takeaway and convenience food. He had been out of work for two months and said he was happy budgeting on jobseekers allowance and housing benefit.

[3] An inflammatory brain disease caused by thiamine deficiency that affects people with long term excessive alcohol use.

5.6 Mr A's first contact with specialist mental health services was on 2 June 2008 when he was admitted as an informal[4] patient after assessment under section 136 of the Mental Health Act 1983. He had walked into a police station saying he was having ideas of self-harm and hearing voices telling him to kill people. He had a knife. The consultant psychiatrist responsible for Mr A's inpatient treatment was consultant psychiatrist 1. When Mr A was discharged on 16 June his diagnosis was mental and behavioural disorder due to use of alcohol (ICD10 code F10.5). Mr A was readmitted in similar circumstances on 19 June. He was discharged on 9 July with a diagnosis of organic psychosis – hallucinosis (ICD10 code F06.0). We will consider the rationale for these diagnoses.

5.7 Mr A spent two weeks in hospital from his first admission and three weeks from his second admission, a total of five weeks, during which the MDT observed and assessed him with tests and examinations. On both occasions he was admitted as an informal patient following an assessment under section 136 of the Mental Health Act. The CTP was unable to contact him after his second discharge. There was a third section 136 assessment on 21 July 2008 when Mr A was not admitted. He was not seen again by the metal health service.

5.8 The International Classification of Diseases, classification of mental and behavioural disorders (ICD10), includes organic hallucinosis under section F06 - Other mental disorders due to brain damage and dysfunction and to physical disease. The classification does not include the term 'organic psychosis – hallucinosis' but we assume this was intended to mean organic hallucinosis, as indicated in consultant psychiatrist 1's report following the incident.

5.9 The classification of organic disorders says:

> "*…the clinical manifestations resemble or are identical with, those of disorders not regarded as 'organic' in this specific sense restricted to this block of the classification. Their inclusion here is based on the hypothesis that they are directly caused by cerebral disease or dysfunction rather than resulting from either a fortuitous association with such disease or dysfunction, or a psychological reaction to its symptoms, such as schizophrenia-like disorders associated with long-standing epilepsy.*"

[4] He agreed to be admitted so the Mental Health Act was no longer needed.

5.10 The classification highlights four conditions to support the diagnosis of an organic mental disorder:

> *"a) Evidence of cerebral disease, damage or dysfunction, or other systemic physical disease, known to be associated with one of the listed syndromes;*
>
> *b) A temporal relationship (weeks or a few months) between the development of the underlying disease and the onset of the mental syndrome;*
>
> *c) Recovery from the mental disorder following removal or improvement of the underlying presumed cause;*
>
> *d) Absence of evidence to suggest an alternative cause of the mental syndrome (such as a strong family history or precipitating stress)."*

5.11 F06.0 defines organic hallucinosis as:

> "*A disorder of persistent or recurrent hallucinations, usually visual or auditory, that occur in clear consciousness and may or may not be recognised by the subject as such…in addition to the general criteria* [quoted above] *there should be evidence of persistent or recurrent hallucinations in any modality; no clouding of consciousness; no significant intellectual decline; no predominant disturbance of mood; and no predominance of delusions…excludes: alcoholic hallucinosis."*

5.12 We also need to refer to the ICD10 criteria for psychotic disorder in the context of psychoactive substance use (such as alcohol) under F10.5.

5.13 For Mr A's presentation, the classification says:

> *"…a cluster of psychotic phenomena that occurred during or immediately after psychoactive substance use and are characterised by vivid hallucinations, typically auditory, but often in more than one sensory modality…the sensorium[5] is usually clear but some degree of clouding of consciousness, although not severe confusion, may be present. The disorder typically resolves at least partially within one month and fully within six months…includes alcoholic hallucinosis."*

[5] Ability of the brain to receive and interpret sensory stimuli.

5.14 Andrew Sims in 'Symptoms in the Mind'[6] defines pseudohallucination as "*…a perceptual experience which is figurative, not concretely real, and occurs in inner subjective space, not in external objective space. It may have definite outline and vivid detail. It may be retained for some time and it cannot be deliberately evoked. It is sometimes described as an 'as if' experience, or in similar explanatory terms…*" In other words, a pseudohallucination is an internal experience, unlike a hallucination which is perceived as an external experience.

5.15 Mr A's case notes documented a three to four week history of hearing a voice before his first admission on 2 June 2008. He said he had been close to his sister-in-law and had carried her coffin at her recent funeral. There was a lack of certainty in the case notes about these experiences with frequent references to Mr A "*not experiencing psychotic symptoms*" during both admissions, based on observations of his behaviour. His experiences were not precipitated by external stimuli but were internal. It was suggested by the junior doctor who assessed Mr A at his first admission (SHO1) and by consultant psychiatrist 1 in his retrospective report that they were pseudohallucinations. Mr A was prescribed the antipsychotic quetiapine the day after admission, with a gradual increase in the dose.

5.16 Consultant psychiatrist 1 told us he did not believe Mr A had a mental illness like schizophrenia or any psychosis, confirming the impression given by the case notes, and said he found it difficult to diagnose Mr A according to any recognised category. He confirmed that Mr A did not appear to be having real hallucinations but he wondered if he was having pseudohallucinations. Consultant psychiatrist 1 told us he prescribed antipsychotic medication in case Mr A was in the early stages of developing his first psychotic illness, although he agreed this was unlikely at the age of 52. Consultant psychiatrist 1 said he gradually increased the dose of quetiapine and Mr A said the voices were diminishing.

5.17 Ward staff drew up a care plan for Mr A at his first admission. It focused on using coping strategies when he heard voices and taking medication. A similar plan at Mr A's second admission added monitoring the effects of his medication. It was revised two weeks later with a focus on monitoring the side effects of his medication but did not mention coping with voices.

[6] Sims, A Symptoms in the Mind, An Introduction to Descriptive Psychopathology. Second Edition (1995). W. B. Saunders. London. pp.92-95

5.18 At his clinical review on 5 June 2008, when Mr A had been on the ward for a few days, the staff grade doctor noted that he appeared settled. Ward staff had found no objective evidence of psychotic symptoms, although Mr A said the voice in his head was continuous. He said he felt emotional because staff treated him well and he was not used to it. Mr A said he was having problems with his memory and sometimes could not remember where he lived. He said he lived on his own and his appetite had improved since he had been admitted.

5.19 The case notes refer elsewhere to abnormalities of memory reported by Mr A. He gave his name at the police station on 2 June but could not remember his address. He insisted a few days later that when he was admitted he could not remember his name or address but could always remember information about football. Mr A's cognitive state was examined using the Folstein Mini-Mental State Examination (MMSE), which is usually used to examine patients with dementia. He scored 27 out of 30. His errors were not knowing the month, one problem with calculation and one error in short-term recall. Consultant psychiatrist 1 told us the test results were in the normal range, he did not think Mr A had dementia or indeed any cognitive impairment and he could function well on the ward. There was no evidence he had trouble finding words.

5.20 The notes also refer to Mr A's history of cerebrovascular disease and a stroke he had in May 2004. We saw a copy of the provisional report of the CT[7] scan which said: '*There is a recent non-haemorrhagic ischaemic infarct*[8] *in the right parietal lobe, involving the cortex and subcortical white matter (Rt MCA territory)'*. The case notes refer to another CT scan on 2 January 2007 during an admission for headache, which showed no changes and no recent stroke. The acute trust records corroborated these findings. When Mr A was first assessed under the Mental Health Act, the approved mental health practitioner noted that he said he had had '*two mini strokes*' in 2004. Three days later Mr A mentioned the two minor strokes again to ward staff, who passed the information to medical staff as part of a query about medication. Mr A's history of two strokes in 2004 was not referred to anywhere else.

[7] Sectional view of the body by computed tomography.
[8] Area of damaged tissue resulting from obstruction of local circulation.

5.21 Mr A was referred to the older people's community mental health team (CMHT). The referral letter written by a junior doctor (SHO2) on 9 June said:

> "*Mr A had right middle cerebellar tree infarct in 2004 with no residual left sided weakness. CT scan of 10 May 2004 revealed a non-haemorrhagic ischaemic infarct in the right parietal lobe involving the cortex and subcortical white matter. He had a repeat scan in 2007 which revealed no new pathology…scheduled for an MRI*[9] *scan."*

5.22 We asked consultant psychiatrist 1 what was meant by '*cerebellar'* as we had seen no evidence of a cerebellar stroke. He told us the radiology reports were not in Mr A's case notes so he asked SHO2 to go to the radiology department to look at them. He said the content of SHO2's letter reflected what he had seen. Consultant psychiatrist 1 obtained a copy of the original full report of the 2004 scan and sent it to us. The report said: '*There is an area of low attenuation, involving the cortex and subcortical white matter of right parietal lobe, consistent with a recent, non-haemorrhagic infarction in the territory of right middle cerebral artery. The rest of the cerebral hemispheres including cerebellum and ventricular systems are other wise normal.'* Having seen this report, which did not indicate a cerebellar stroke, we do not know if the word '*cerebellar*' in SHO2's letter to the older people's CMHT was a typing error or a misunderstanding about the report.

5.23 We consider the referral to the older people's CMHT further in the section on internal referral policies and procedures below.

5.24 Consultant psychiatrist 1 made the request for an MRI brain scan soon after Mr A's first admission. The consultant radiologist's report of 12 June 2008 said:

> *"An old*[10] *left posterior frontal infarct demonstrated. No evidence of new infarction. There is no SOL* [space occupying lesion]."

5.25 Mr A's stroke in 2004 involved the right hemisphere and in particular his parietal lobe. This infarct was not mentioned in the report of June 2008 (it may no longer have been visible) and the "*old"* infarct which was reported, was on the other side of the brain

[9] Magnetic resonance imaging
[10] 'Old' is usually taken to mean more than a month ago. 'Fresh' is taken to mean within the last week.

in the left hemisphere, more anterior than the infarct of 2004, involving the posterior frontal lobe.

5.26 At Mr A's clinical review on 16 June 2008 with consultant psychiatrist 1, SHO2 recorded: '*MRI – no new findings*.' There was no acknowledgement in the notes of this later left frontal stroke. SHO2's discharge letter of 20 June said: '*Quetiapine was titrated up to 250 mg, considering his background of a stroke in 2004 ... He had a repeat MRI scan which showed an old left posterior frontal infarct.'* It was not clear from this letter that these were two different strokes.

5.27 SHO2 then wrote a request for an EEG on 23 June which said:

> "*Left posterior frontal infarct in 2004. Repeat MRI reveals no new abnormality (06/08)."*

5.28 Consultant psychiatrist 1 mentioned the two strokes in his retrospective report after the incident of 2009 and during his interview for the CTP's internal investigation. His report stated:

> *"Coexistence organic psychopathology such as right middle cerebellar infarct, right parietal lobe involving the cortex, non haemorrhagic ischaemic infarct and old left posterior frontal infarct haven't had confirmation in his clinical picture*."

5.29 Medical staff recorded no comments in the case notes about a second stroke before the incident of 2009.

5.30 Consultant psychiatrist 1 told us he did not realise that SHO2 appeared to have conflated the right and left strokes in his EEG request. Consultant psychiatrist 1 confirmed to us that he knew at the time that the MRI scan of June 2008 identified a stroke in the left side of the brain.

5.31 The GP records and acute trust notes regularly documented Mr A's long history of alcohol excess. We set out details of his reported history of alcohol use in the section below on the alcohol service. He reported heavy drinking in 1994 and 1999; moderate in 2004; excessive in 2005 until he received help from an alcohol counsellor at the GP surgery and then heavy again in 2007. We do not know what was happening in between these

reports but when Mr A was admitted to the mental health service in June 2008, staff heard from the GP out-of-hours service that he was drinking up to 86 pints a week. Blood tests performed on the mental health ward identified highly elevated liver enzymes and other abnormalities indicating continued heavy drinking.

5.32 Mr A initially said he had drunk three pints of beer on the afternoon of his first admission but later said his last drink had been three days before. Staff noted a risk of withdrawal from alcohol on the risk assessment of 2 June. They noted that Mr A did not appear to be suffering any symptoms of withdrawal on the risk assessment evaluation of 16 June.

5.33 As an informal patient Mr A was free to leave the ward in agreement with staff. Staff suggested he should have time away from the ward nine days after his admission, as he was calm and settled. On his first outing he went to the opticians. Staff suspected Mr A had been drinking after his second outing from the ward on 13 June, but he denied it. He went out in the afternoon two days later and said at his review the next day that he had "*about 6 pints of beer"*. A note on another day said: "*No alcohol during leave though was at the pub"*. Staff rarely recorded after leave from the ward whether Mr A had been drinking but they regularly noted he was in a good mood on his return. On his second admission late on 19 June Mr A said he had only drunk a small shandy with his lunch but staff felt there was a stronger smell of alcohol and he looked unkempt.

5.34 Mr A told us he did drink when he had leave from the ward and went into town.

5.35 Nursing staff recorded five comments about Mr A's shaking hand, sweating, tremor and difficulty in writing. The stroke consultant had discharged Mr A in 2004 with '*no weakness in his limbs'*. There was no record of tremor when he was admitted to hospital with a severe headache in 2007.

5.36 Mr A's GP reviewed his mental health on 18 November, four months after his discharge from hospital. He noted "*alcohol currently nil"* and "*nondependent alcohol use - well controlled, no cravings, no alcohol in morning, twice a week, drinks 16 units per week"*.

5.37 Consultant psychiatrist 1 said in his retrospective report that the clinical picture presented by Mr A seemed "*close to alcoholic hallucinosis when the patient is usually*

distressed by voices recurring thoughts of threats. On the other hand appears anxious and restless." This later view was not recorded in Mr A's case notes.

5.38 Consultant psychiatrist 1 told us he thought Mr A's presentation was similar to alcoholic hallucinosis and he wondered if Mr A was having seizures because of withdrawal from alcohol but he agreed that nursing staff were watching for signs of withdrawal and recorded that they did not see any. Mr A had been prescribed medication to ease withdrawal if needed but was never given any. Consultant psychiatrist 1 also told us that Mr A's symptoms did not fulfil the criteria for alcoholic hallucinosis and he thought Mr A was suffering from alcohol dependence rather than a mental illness. He said he was optimistic about Mr A's chances of recovery from alcohol dependence. These views were not recorded in the case notes and Mr A was discharged with a diagnosis of organic hallucinosis.

5.39 We consider Mr A's drinking further in the section on internal referral policies and procedures below.

5.40 An EEG was carried out on 27 June during Mr A's second admission. The report said:

> *"The EEG shows several episodes of mixed slow and sharp components. These are usually bilateral but sometimes with right-sided emphasis or occasionally appearing solely on the right. These features are most likely due to the antipsychotic medication suggesting lower seizure threshold."*

5.41 Consultant psychiatrist 1 prescribed sodium valproate as epilim chrono, an anticonvulsant, as a result of this investigation.

5.42 Consultant psychiatrist 1 told us there was no evidence Mr A ever had any observable epileptic seizures. He said he needed to rule out temporal lobe epilepsy with simple partial seizures because the clinical picture could be similar to pseudohallucinations, in that the person has no loss of consciousness but might experience hallucinations. The neurophysiologist reported abnormalities in Mr A's brain waves and attributed these to antipsychotic medication. Consultant psychiatrist 1 told us he disagreed and prescribed anticonvulsant medication to raise the seizure threshold and protect Mr A from complex partial seizures. We asked consultant psychiatrist 1 if he

discussed his thoughts with the neurophysiologist and he said he did not because he had a clear report from him. Nor did he discuss the case with any other specialist.

5.43 Consultant psychiatrist 1 referred us to Maudsley Guidelines[11] about the use of an anticonvulsant for people with untreated epilepsy. He confirmed he did not think Mr A had epilepsy or showed any evidence of alcohol withdrawal. These guidelines go on to discuss the use of an anticonvulsant for people who have had more than two withdrawal seizures and say there is no need to continue this medication if it has been used to treat a seizure related to alcohol withdrawal.

5.44 Nursing staff recorded their concerns about Mr A's physical health on two occasions. On 21 June they recorded that Mr A felt unwell and checked his vital signs. He had low blood pressure and a fast pulse and they consulted the doctor on call. Mr A rested on his bed, and then got up and said he felt better. When SHO2 reviewed him four days later Mr A said the medication was helping but he felt very drowsy. SHO2 reduced his dose of quetiapine and added aripiprazole after speaking to consultant psychiatrist 1. Consultant psychiatrist 1 told us he decided to change to aripiprazole because of the possibility of quetiapine causing a drop in blood pressure when standing up.

5.45 Nursing staff recorded that Mr A complained of shooting pains in his left arm on 7 July. They checked his vital signs and took him to A&E where he was given an inhaler and painkillers, had x-rays and an ECG and was advised to see his GP about his chest in a few days. Mr A seemed fine when he returned to the ward and later that day went on leave for two days. Medical staff made no record on either of these occasions and there was no record from the A&E department (or of the ECG) in his case file.

5.46 Nursing staff noted the dates of six one-to-one sessions during Mr A's first admission and ten one-to-one sessions during his second admission. It was not always clear from the main notes what had been discussed.

5.47 Information was obtained from the out-of-hours GP service about Mr A's address and his heavy use of alcohol when he was first admitted, but there was no evidence of other contact with the GP practice while he was on the ward. Mr A initially gave the ward his mother's telephone number and permission to contact her. A week later he told staff

[11] 10th edition page 296

they should only contact his mother in an emergency but there was no evidence of an attempt to persuade him that contact with his family could help his care and treatment.

5.48 Mr A's parents told us he was normally in touch with the family twice a week and sent birthday cards. They were desperate to contact him after he stopped calling before he was admitted in June 2008 and felt there must be something wrong. They were out of touch until Christmas 2008.

5.49 We asked Mr A what he could remember about his stroke in 2004. He told us in some detail about a barmaid commenting that he did not seem well and suggesting he might have had a stroke because his face was lopsided. He drank four pints of beer and went home before going to hospital. We asked if he had ever had another stroke and he said he had an unclear memory of having one in October the same year but he was not aware of any others.

5.50 Mr A told us that when he was on the mental health ward "*they just seemed to let me get on with things – I didn't seem to get any treatment*". He said he was on medication but could not remember having one-to-one sessions.

5.51 Mr A told us people were around all the time when he was at the hostel and he was all right when he was in pubs. He said the voices started again when he was alone in his flat (which he moved to after Christmas 2008). He thought he was still taking his medication. He no longer had a keyworker when he was at his flat and he heard voices when he was alone.

Findings

5.52 Mr A was admitted twice because he went to a police station with a knife, saying a voice was telling him to kill other people. He spent five weeks in hospital.

5.53 Ward staff frequently noted Mr A was experiencing no psychotic symptoms based on their objective assessment and the absence of signs that he was responding to external stimuli. The MDT agreed that Mr A did not have psychotic symptoms but he was prescribed antipsychotic medication from the day after his first admission.

5.54 Inpatient care plans focused initially on coping with hearing voices and taking medication and then shifted to solely monitoring the side effects of medication. There was no description of or reference to the coping strategies mentioned in the early care plans.

5.55 Mr A settled easily on the ward and said he was not used to being treated so well.

5.56 Mr A had been on the ward a few days when he insisted that he could not remember his name and address when he was admitted, but there was no record in his case file that he could not remember his name either at the police station, or on admission. Mr A scored 27 out of 30 in the MMSE.

5.57 There was evidence of two strokes in Mr A's clinical records. The first was the right parietal infarct in 2004 and the second involved the left posterior frontal lobe seen in June 2008. The CT scan in January 2007 when Mr A was admitted with a severe headache revealed no abnormality. There was no documented history from Mr A or from his GP of a stroke after 2004 and no evidence that he was questioned about this.

5.58 The first discharge letter mentioned the stroke in 2004 and the repeat MRI showing the left stroke without making it clear these were two separate strokes. There was no other reference to both right and left strokes anywhere in the mental health case notes or correspondence.

5.59 The referral letter for assessment by the older people's CMHT and the referral form for an EEG each had incorrect information about Mr A's strokes.

5.60 Mr A had a documented history of heavy drinking and blood test results typical of people with alcohol problems who are actively drinking. He gave contradictory accounts of his drinking before admission and during agreed periods of leave from the ward. He told us he did drink when he went into town from the ward.

5.61 Staff knew Mr A might experience symptoms of withdrawal from alcohol and noted that they did not observe any such symptoms.

5.62 Nursing staff noted Mr A's tremor, sweating and difficulty with writing but there was no evidence in the records that this was discussed with or considered by the medical staff.

5.63 The GP was aware of Mr A's history of problem drinking and concluded on 18 November 2008 that his alcohol use was well controlled.

5.64 Mr A's diagnosis at his first discharge was mental and behavioural disorder due to the use of alcohol. By the time of his second discharge the diagnosis was organic hallucinosis and alcohol was not mentioned as a problem on the discharge form or in the discharge letter, except for a reference to *'deranged liver function test'* in his medical history. There was no discussion in the case notes of the possibility of alcoholic hallucinosis.

5.65 An EEG was carried out during Mr A's second admission and Mr A was prescribed sodium valproate as epilim chrono. The case was not discussed with the neurophysiologist or with a neurologist.

5.66 Consultant psychiatrist 1 did not think Mr A was psychotic, or had epilepsy or had experienced alcohol withdrawal.

5.67 Medical staff did not record the two occasions when nursing staff were concerned about Mr A's physical health, and there was no record from the A&E department of his escorted visit or the outcome of the ECG on 7 July.

5.68 No information was sought by the MDT about Mr A's psycho-social history from his GP, his family or anyone else who knew him. He told psychologist 1 he had been unemployed for two months but ward staff did not record when he stopped working or why.

5.69 Staff were not aware that Mr A's family were desperate to contact him.

Comment

5.70 ***We considered the diagnosis of organic hallucinosis and in particular the organic cause of any supposed psychotic symptoms in relation to the diagnostic criteria outlined above. There was evidence in the records of cerebrovascular disease and two strokes. The first stroke was on the right in 2004 but we do not know when the second one on the left occurred. The lack of apparent change on the***

CT scan of January 2007 has two possible explanations. Mr A may just have had his second stroke when he was admitted to hospital with a severe headache but the scan did not find it. CT scans are not as sensitive as MRI scans, so the scan may have missed the stroke or it may have been too soon to see the signs in his brain. Alternatively, Mr A may have had his second stroke after January 2007 but before the MRI scan of June 2008. The radiologist reported in June 2008 that the left frontal infarct was old and so it would be difficult to tell whether a few weeks or a few months had passed between the stroke on the left and the start of Mr A's mental health problems.

5.71 *The MDT were clear that Mr A did not have psychotic symptoms but they did not record any discussion of what they thought was causing his pseudohallucinations. His experience of persistent hallucinations (if he had any) would be consistent with the diagnosis of organic hallucinosis that was made, as the supposed hallucinations happened in clear consciousness and had a quality that Mr A had some insight into. However, it would also not be out of line with a diagnosis of alcoholic hallucinosis which we will also consider.*

5.72 *Mr A's early care plans mentioned the need for coping strategies when he heard voices but there was no description of these coping strategies and no evidence from the case notes that they were discussed with Mr A after the first care plan was drawn up. This suggests staff were not convinced he was hearing voices despite his continued reference to them. It would have been helpful to explore these reported experiences with Mr A to understand how real they were, what might be triggering them, or why he said he heard voices if it was not true. Ward staff might have had such discussions with Mr A, but they did not document them.*

5.73 *The diagnosis of organic hallucinosis implied that the stroke(s) were causing psychosis. The evidence in the case notes did not support this. First, the MDT did not believe Mr A's symptoms were psychotic. Secondly, we do not know the time between the second stroke and the onset of the symptoms. Thirdly, the alternative cause of hallucinosis relating to Mr A's drinking was not apparently considered. No discussion was recorded in the case notes of this possibility. In order to be clear about a diagnosis of organic hallucinosis, there needed to be further consideration of Mr A's cognitive state to establish that he did not have any intellectual decline and to*

determine the impact of the left frontal infarct on his cognitive state. Evidence was needed of a brain disorder or a more clearly identified underlying organic cause.

5.74 *The treatment plan with quetiapine, an antipsychotic, was appropriate for a diagnosis of organic hallucinosis. However, it was not clear that Mr A was suffering from organic hallucinosis and yet the medication was started the day after admission. Mr A's reported 'voice' appeared to resolve quickly over another few days. It would have been worth delaying a pragmatic trial of antipsychotic treatment to see whether there was any resolution of his reported symptoms without it and while further investigations were carried out, including neuropsychological assessment. Mr A was calm and pleasant and did not need tranquilisation so it would have been safe to wait. We were surprised to hear from consultant psychiatrist 1 that he prescribed an antipsychotic in case Mr A was developing his first psychotic illness, as this would be fairly unlikely in someone of Mr A's age and history. However, the MDT appeared to believe the medication had been effective in reducing Mr A's (pseudo)hallucinations and this was one of the reasons for discharging him from hospital.*

5.75 *It is well known that the MMSE is not sensitive to subtle changes in cognition and does not examine frontal lobe function effectively. It is a basic test for dementia which Mr A did not have. Mr A's reported inability to remember his address when he was at the police station might just have been a symptom of psychological stress, given his virtually normal MMSE and no other signs of severe dementia. The records do not support his retrospective claim that he also could not remember his name – but staff did not appear to take this seriously.*

5.76 *It is important to differentiate alcoholic hallucinosis from the condition delirium tremens[12] which often includes disorientation, confusion and agitation. There was no discussion of the possibility that alcohol misuse could have led to hypertension and strokes.*

5.77 *Nursing staff who noted Mr A's tremor and difficulty in writing were understandably unclear if this was caused by stroke or alcohol. They should have discussed it with the medical staff who should have considered a neurological*

[12] Tremors induced by withdrawal from excessive and prolonged use of alcohol.

examination. These symptoms might also have been exaggerated by anxiety when staff were talking to him more formally and filling in forms.

5.78 *Alcoholic hallucinosis usually lasts less than a day and rarely more than a few days. Withdrawal from alcohol appears to be the chief factor leading to transient hallucinations, although sometimes people report hallucinosis when they continue to drink. For most people the hallucinations clear within a week. They can become chronic and persist for months or years, although this is less common. Nursing staff were looking for symptoms of withdrawal from alcohol and did not see any.*

5.79 *There was evidence in the records that Mr A continued to drink heavily despite brief periods of abstinence at the start of his admissions. Mr A was inconsistent in his reports of what he had drunk just before admission. Ward staff occasionally suspected he had been drinking during agreed periods of leave but they rarely questioned him about it when he returned. They seemed satisfied that he was in a pleasant mood.*

5.80 *In addition, the blood investigations which confirmed Mr A's harmful drinking, alongside his history of excessive drinking, should have played a more prominent role in the consideration of Mr A's diagnosis and presentation. There was no recorded consideration of the significance of these blood results.*

5.81 *We were not confident that Mr A's alcohol use was fully taken into account, particularly during the second admission when the diagnosis referred to a psychotic disorder rather than an alcohol related condition. Consultant psychiatrist 1 concluded retrospectively that Mr A might have been suffering from alcoholic hallucinosis or just alcohol dependence, but the case notes did not contain evidence of any discussion of this possibility.*

5.82 *A more thorough approach to his drinking and its relationship to his presentation would have been more important than considering the other possible organic origins of Mr A's symptoms. Excessive drinking seems a more likely cause of Mr A's neurological and psychiatric presentation. A neuropsychological assessment would have helped establish the role of any underlying cognitive impairment.*

5.83 *The stroke in the left hemisphere was only mentioned in the first discharge letter. There was no reference to it in the case notes or any other communication. The case notes read as if the two strokes were considered as one. The EEG request written by the junior doctor indicated that he thought the left stroke described in the recent MRI report was the stroke that occurred in 2004. The damage seen in 2004 was actually on the right side of the brain. In addition, the junior doctor's referral letter to the older people's CMHT described the first stroke in 2004 as a* "right middle cerebellar tree infarct" *although the radiology report did not indicate a cerebellar infarct.*

5.84 *We were concerned by the lack of evidence that the MDT were clear about the later left posterior frontal lobe stroke or of its potential significance. Consultant psychiatrist 1 said he did not know the information in the EEG referral was wrong. The case notes did not comment on the relative role of this second stroke and there was no evidence that it was discussed. Although ward staff assessed Mr A's behaviour and general ability to function during his admissions, no one examined the frontal lobe function to assess whether this was impaired.*

5.85 *It would have been useful to find out whether Mr A had any evidence of personality change as a result of the second stroke, or other features of a frontal lobe syndrome such as increased impulsivity, increased agitation or aggression, lessening of inhibition, and so on. Any such change would have been magnified by alcohol and posed a greater risk if he was not aware of it. This would have needed a wider enquiry involving his family or someone like his GP, in addition to neuropsychological examination at best, and bedside testing at least. However, we accept that Mr A's demeanour on the ward gave no obvious cause for concern, quite the opposite.*

5.86 *Mr A said he only wanted his mother contacted in an emergency but we were concerned there was no evidence of an attempt to persuade him of the value of involving his family in his care and treatment. It is good practice to involve families, wherever possible, even if there is no identified carer. Mr A's parents were not his carers and he had not been in touch with them for a few weeks but staff did not realise his family were desperate to contact him and to offer him support.*

5.87 *Consultant psychiatrist 1 told us that Mr A had no history of seizures but he requested an EEG to rule out a type of epilepsy which could cause pseudohallucinations. We were surprised that consultant psychiatrist 1 disregarded the neurophysiologist's view that abnormalities in Mr A's brain waves were probably due to the antipsychotic medication, and prescribed anticonvulsant medication without discussing it with the neurophysiologist or a neurologist with expertise in managing epilepsy, however experienced he was. Consultant psychiatrist 1 told us he prescribed the anticonvulsant to protect Mr A from complex partial seizures. This was a complex case and, in our view, complexity should lead to an exchange of views between colleagues.*

5.88 *The findings of the EEG were not unusual in the context of antipsychotic medication. Antipsychotics may reduce the seizure threshold but this does not mean there will be seizures and none were reported in Mr A's clinical history or while he was on the ward. His drinking made him vulnerable to withdrawal seizures, but these are rarely managed with anticonvulsant medication. It would have been important to ask for a neurological opinion about starting an anticonvulsant in this situation and in most cases, unless the consultant psychiatrist had experience of routinely managing epilepsy.*

5.89 *The prescription of antipsychotic and anticonvulsant medications might have suggested to Mr A that he was not responsible for his actions, because these were 'medical problems'. It might also have implied that alcohol was not important and there was some other disorder. In fact there was no documented assessment of the potential resolution of his symptoms without medical treatment or without alcohol. Similarly, while he might have had underlying frontal brain damage and this might have been linked to risk and impulsivity that was magnified or disinhibited by drinking, this was not considered in the ongoing assessment.*

5.90 *Nursing staff took prompt and appropriate action when they were concerned about Mr A's physical health and recorded their findings, but medical staff made no records at the time. There was no record from the A&E department (or of the ECG) in Mr A's case file, even though the A&E department was in the same hospital and it should have been easy to obtain copies.*

5.91 ***Consultant psychiatrist 1 considered alternative potential diagnoses in his retrospective report and said Mr A did not fulfil the criteria for personality disorder because of his compliant behaviour, his general functioning on the ward and his lack of problems with social interactions. However, this was not documented in the case notes and there was no contact between the ward team and Mr A's family about their experience.***

5.92 ***Consultant psychiatrist 1 also said in his retrospective report that the ward team could not detect any mood disorder or adjustment reaction. However, the case notes did not indicate that this had been adequately investigated. Another potential differential diagnosis that would have been worth considering was long term brain damage from alcohol misuse as there was no evidence that he had stopped drinking for any significant period. Interestingly, staff at the acute hospital suggested a diagnosis of Wernicke's encephalopathy the day before Mr A was admitted with his first stroke in 2004, although this was not assessed at the time. We consider Mr A's history of alcohol use in more detail in the section on the alcohol service below.***

5.93 ***It would have been particularly good practice to contact a forensic specialist for advice on Mr A's assessment without necessarily making a referral (we will consider his risk assessment in the next section).We recognise that the forensic service was unlikely to take over Mr A's care and treatment and that he would not have been admitted to a low secure unit because he had no forensic history and he was compliant on the ward. The point is to liaise, share and discuss complex cases with colleagues rather than refer with a view to transfer.***

5.94 ***There appeared to be a lack of psychological thinking about Mr A's situation and an over reliance on medication as the answer to his problems. He may have had some brain damage affecting his thinking and behaviour and he needed to drink less, but there were other important factors. He was distant from his family, recently unemployed, probably lonely and unsupported in the community, had no known activities other than going to the pub and was subject to various stresses. He appeared happy and settled in the ward environment. Mr A's comment that he felt emotional because staff treated him so well seemed highly significant.***

5.95 ***It is difficult to think psychologically in a busy inpatient setting. Mr A would have faded into the background if there were other people needing urgent attention***

and staff may not have got to know him better if he had stayed on the ward. He probably needed a completely different approach, based in the community with regular contact and the opportunity to talk about his anxieties. He needed help to learn to express his needs in a less dramatic way than going to the police station with a knife.

Conclusion

5.96 There were some inconsistencies and apparent contradictions in Mr A's diagnosis and treatment. Staff were clear that he did not have a psychotic illness but there was insufficient consideration of the possibility of an organic disorder causing his presentation and some of the information available was misinterpreted or not considered. There was no documented discussion about the effect of his alcohol use. The MDT seemed uncertain about the cause of Mr A's presentation, but antipsychotic and anticonvulsant medications were prescribed quickly without being clearer about the diagnosis. There was no record of multidisciplinary assessment, discussion or consideration of Mr A's case and there was a predominantly medical explanation despite the lack of evidence to support it. There were no discussions with other disciplines including neuropsychology, clinical psychology, neurophysiology or neurology that might have helped the team reflect on the diagnosis and treatment plan.

5.97 Mr A presented the MDT with a complicated picture of self-reported hallucinations, documented heavy drinking and possible brain damage. The MDT requested appropriate investigations but missed some opportunities for clarification and consultation. The various elements of Mr A's assessment and treatment did not appear to have been considered as a whole, or discussed within the MDT.

Recommendations

R1 NAViGO should encourage senior clinicians to contact specialists by telephone about the management of actual or suspected physical comorbidity [eg organic brain disease], especially where there are abnormal findings, and to document these discussions. [see paragraphs 5.87, 5.88, 8.147]

R2 NAViGO should encourage senior clinicians to reflect on diagnostic uncertainty and discuss complex cases with peers on an informal basis in addition to discussions within the clinical team. Discussions must be documented in clinical records and in minutes of team meetings. [see paragraphs 5.93, 8.151]

R3 NAViGO should ensure consultant psychiatrists either make or countersign a single entry in the clinical records that clarifies the formulation and opinion of the team after pulling together the opinions of different disciplines. This entry should include the rationale for treatment decisions especially when such decisions are controversial or not supported by clinical evidence or are off license. NAViGO should audit this standard. [see paragraphs 5.71, 5.73, 5.81, 5.89]

R4 NAViGO should ensure current operational guidance emphasises the potential benefit of contacting close associates of the service user, even if he has no formally identified carer. [see paragraph 5.86]

6. Risk management

6.1 In this section we examine how the MDT identified and managed the risks Mr A posed and we consider the safety and security of the care setting.

Risk management process

Evidence

6.2 At the time of Mr A's care and treatment the CTP was using the DICES[13] risk assessment tool, which was incorporated into the policy on CPA.

6.3 The CTP's internal investigation concluded that risk assessment was not robust. We agree and have therefore not examined this aspect in detail. The case notes show a DICES risk assessment was carried out on his first admission, documented and evaluated. It focused on the decrease in Mr A's supposed hallucinations, the effects of medication and the risk of withdrawal from alcohol.

6.4 During Mr A's first admission he had given permission for his mother to be contacted, but staff noted he later said he only wanted his mother to be contacted in an emergency "*unless he was admitted to somewhere high security*". He also told them he hoped he could sort himself out in a unit like Rampton but there was no further information or record of any other discussion about this.

6.5 Staff noted that at Mr A's seven-day follow-up on 18 June after his first discharge he said he had managed to resist the urge to carry a knife when he left the house but he felt he would in the near future because the voices telling him to kill other people were overwhelming. He was frightened he might harm someone. Staff told him that carrying an offensive weapon was illegal. Mr A said he had been taking his medication but felt mentally unwell. The staff grade doctor, SHO2 and two nurses assessed Mr A and decided he did not need to be readmitted. He was advised to stop drinking alcohol and to contact the crisis team or come to A&E if the voices got worse. They noted that he was '*to be seen soon*' by the community consultant. The appointment had in fact been arranged for 12

[13] DICES (describe, investigate, choose, explain, share) – property of The Association for Psychological Therapies

August. There was no record of a new risk assessment or of any contact with the community consultant. Mr A was admitted the next day after he walked into a police station carrying a knife and said voices were telling him to kill someone.

6.6 Ward staff and a police constable held a meeting during Mr A's second admission when they agreed that Mr A knew right from wrong and knew that carrying a knife on the street was a criminal offence. He was to be advised to contact mental health services at times of distress, instead of the police, who were likely to take action if he contacted them again in possession of a knife. Ward staff informed the forensic team that the criminal justice system should process Mr A if he came into contact with police again rather than being assessed under the Mental Health Act. Mr A was then informed of the MDT's decision that he knew right from wrong and the police would take action. There was no indication in the records that he was encouraged to contact the mental health service in future instead of the police. The CTP discovered during their internal investigation that the police had no record of the meeting and would not have been able to confirm what action might be taken in the future.

6.7 We found no evidence that psychologist 1 was involved in any discussion of Mr A's risk assessment. She saw him once for an initial interview and was not invited to an MDT meeting about him. The MDT thought psychologist 1 did not need to see him again. We explore this in more detail in the section on the psychology service below.

6.8 Consultant psychiatrist 1 and the outpatient consultant (consultant psychiatrist 2) were not informed of Mr A's third presentation at the police station on 21 July 2008, when he was carrying a knife and saying that a voice was telling him to kill someone. The director of operations told us that NAViGO now has a mechanism in place to inform consultants and GPs that one of their service users has had a section 136 assessment that did not result in admission.

6.9 The case notes commented regularly that Mr A took his medication. At his second discharge on 9 July staff recorded that Mr A said it was helping and he would continue taking it. The approved mental health practitioner (AMHP) noted on 21 July at his third section 136 assessment that Mr A said he was taking his medication but it was not helping. The consultant psychiatrist who assessed him on this occasion was going to send an email to Mr A's GP suggesting changes to his medication to alleviate the voices with minimal side effects, but there was no record in the case notes that the email was sent. Staff felt Mr A

hoped to be admitted but they decided not to admit him. Mr A's GP recorded that he reviewed his medication on 18 November. Mr A was taking his repeat medication and Mr A felt it was controlling his symptoms.

6.10 The director of operations told us risk assessments were not being carried out consistently at the time but the organisation had made progress in terms of when risk assessments should be carried out and reviewed, and in terms of the retention and review of historic information. He explained that care coordinators should generate a chronology of significant incidents in one place in the file but that had been inconsistent. Compliance with the risk policy is included in the annual audit programme and monitored on a case by case basis in supervision. He felt the service was in a better position but still had work to do, particularly in teams with high caseloads.

6.11 The director of operations informed us that, since the incident, the CTP and NAViGO have introduced new and more robust processes for risk management supported by a training programme.

Findings

6.12 The DICES risk assessment tool was used for Mr A. Risk assessments were documented and focused on the decrease in Mr A's supposed hallucinations, the effects of medication and the risk of alcohol withdrawal.

6.13 Staff often noted that Mr A was pleasant and appropriate on the ward with no signs of psychosis or violent behaviour. He had no history of violence or significant antisocial behaviour.

6.14 Staff monitored Mr A's compliance with medication and he always said he was taking it.

6.15 The MDT considered the risk of Mr A's self-reported hallucinations and discussed with the police Mr A's capacity to understand the significance of carrying a knife.

6.16 The forensic team were informed of the meeting with the police but no discussion with the forensic team or other specialists about Mr A's risk profile was recorded. There

was no record that Mr A was advised to contact the mental health service instead of the police. The police could advise but not predict what action might be taken in the future.

6.17 The risk assessment records did not mention his current drinking or history of excessive drinking.

6.18 There was no record of any consideration of the potential effects of Mr A's frontal brain injury.

6.19 The psychology service was not involved in any discussion about Mr A's risk assessment. Psychologist 1 saw Mr A once and the MDT thought she did not need to see him again.

6.20 Staff had no contact with Mr A's family or anyone else who could have provided information about his history and any recent changes.

6.21 The psychologist recorded in her notes that Mr A had been unemployed for two months. The reason for his unemployment was not recorded by anyone.

6.22 Staff did not record any discussion of Mr A's comment about sorting himself out at Rampton.

6.23 There was no documented risk assessment at the time of Mr A's seven day follow up on 18 June 2008 or his second discharge on 9 July 2008.

6.24 The CTP had no mechanism to inform the inpatient or outpatient consultant of Mr A's third section 136 assessment and staff therefore had no opportunity to reconsider his risk assessment. NAViGO has now put this in place.

6.25 The CTP and NAViGO have worked hard to improve risk management systems with new procedures, training and regular audit.

Comment

6.26 ***The CTP's internal investigation report noted risk assessments focused on symptom control rather than the risk of Mr A acting on the pseudohallucinations.***

There was no evidence that Mr A had ever harmed or threatened to harm other people. The CTP concluded that staff were reassured that Mr A posed a low risk, in spite of significant risk factors. The report said:

> **"Compliant with medication, good insight into symptoms, no previous history, no evidence of violence on ward, no evidence that Mr A was disturbed by symptoms or indeed acted in relation to reported symptoms, generally pleasant and sociable. However there were also factors which (should have) raised concern: the command nature of the pseudohallucinations, carrying a knife, three presentations (two after discharges) and a history of alcohol use which seems significant."**

6.27 *The CTP's report concluded that the MDT had no clearly recorded process of risk assessment, analysis and planning, as well as no focus on significant risk factors. It also noted that the risk profile was not updated when Mr A presented for a third time at the police station.*

6.28 *We agree with the CTP's conclusions on risk assessment, especially the factors which should have raised concern. We also agree that, based on the risk assessment, Mr A could have been followed up and managed in the community but we believe he should have been followed up assertively. We consider the issue of community follow-up in the section below on discharge policy, CPA and post-discharge follow-up.*

6.29 *The DICES risk assessment tool was in use but risk management did not appear to be a joint exercise for the MDT as a whole.*

6.30 *We were particularly concerned that Mr A's risk assessments did not include the risk posed by Mr A's excessive drinking. We do not feel that enough account was taken of Mr A's drinking, in terms of his diagnosis or in terms of the behavioural risks it might have posed.*

6.31 *We do not know what might have been learned from an investigation of Mr A's second stroke and the effect the stroke had on his behaviour, especially in relation to his drinking. The findings might not have made any difference clinically but the MDT was unable to take this into account as part of Mr A's risk assessment. It would have been useful to formulate the relationship between any frontal lobe problems and Mr*

A's potential for violence. Mr A's confusing presentation would have benefited from a more specialised risk assessment and it would have been good practice to share concerns in a discussion with a psychologist, neuropsychologist or possibly a forensic practitioner.

6.32 *The MDT should have tried to seek information from Mr A's family about any personality change, emotional instability or aggression and violence, if the MDT were aware of Mr A's second stroke (and there was no clear evidence that they were). Staff should have had a discussion with Mr A about the benefits of talking to his family even though he had said he only wanted his mother contacted in an emergency. Nevertheless, we accept that staff found Mr A consistently calm, pleasant and compliant and did not observe any behaviour that concerned them.*

6.33 *We feel strongly that not enough was known about Mr A's background and social situation. There was no focus in the records on his home life. We do not know what psychological stress Mr A may have been caused by his living arrangements. We have to conclude staff were so reassured by his pleasant and compliant manner that they felt no need to enquire further into his personal circumstances.*

6.34 *The meeting with the police during Mr A's second admission, to discuss his capacity and an action plan, was good practice but the plan was not fully carried out. It was not clear from the records that Mr A was actually advised to contact mental health services instead of the police. The police had no record of the meeting and in any case could not decide in advance what action might be taken.*

6.35 *There was no system for informing Mr A's consultants that he had come to the police station carrying a knife again and saying that a voice was telling him to kill someone, when Mr A was assessed under section 136 for the third time. This meant there was no opportunity for staff to reconsider his risk profile formally, if it occurred to anyone to do so. NAViGO now has a system to inform consultants of section 136 assessments where there is no admission.*

6.36 *It is unfortunate that staff did not record any discussion, either with Mr A or within the MDT, of Mr A's comment about sorting himself out at Rampton. We can only wonder about the significance of this remark and whether Mr A wanted to be admitted to Rampton Hospital.*

6.37 ***The CTP and NAViGO have taken prompt action to devise and implement new procedures for risk management, a training programme and regular audit. We feel that appropriate attention is being given to risk management and NAViGO is aware of the need for ongoing vigilance.***

Conclusion

6.38 We have to conclude that, despite his consistently calm and pleasant manner on the ward, Mr A presented with some factors suggesting a higher level of risk than the MDT perceived. Risk assessment did not take some significant elements into account. When Mr A left hospital he should have been monitored for a period of time in the community with a better understanding of the risk he might pose to the public. If he had stayed in touch with mental health services he might have been discharged by the CTP, if he seemed as stable as his GP found him in November 2008, but he might also have been more likely to contact mental health services if he needed support. Valuable improvements have been put in place to ensure risk management is more robust.

Safety and security of care setting

6.39 The terms of reference for this investigation do not specifically require us to consider safety and security but concerns were raised with us and we felt it was appropriate to consider these in the context of Mr A's care and treatment.

Evidence

6.40 Psychologist 2 told us she had raised concerns in the past about safety and security in the mental health service. She felt physical security was inadequate, procedures were 'hit and miss' and staff did not have time to get to know people who were discharged too soon. She was concerned that dangerous people had been discharged into the community, the CTP had no hostage-taking policy and the suicide rate was too high. She also felt risk assessment and training in dealing with violence and aggression was poor. We asked psychologist 2 if she had put her concerns in writing before the incident of 2009. She had

not, but she told us she had raised her concerns at meetings of the local board and directly with senior managers.

6.41 Psychologist 1 also told us she had some concerns about safety and risk assessment processes on the wards and about the lack of alarm bells in the psychology department. She said no action was taken because the service was going to move to new premises.

6.42 Consultant psychiatrist 1 told us he had no particular concerns about safety and security on the wards but he felt it was the ward manager's job to check these things. He said there had previously been one locked ward and one open ward. The new accommodation had no seclusion room so safety now depended on face-to-face intervention, which was more challenging for staff.

6.43 The director of operations told us he recalled psychologist 2 discussing the need for a hostage-taking policy and she often reflected on her previous work at Rampton Hospital. He recalled a discussion about the risk one person posed to staff in the psychology department but he did not remember psychologist 2 raising concerns about the physical environment or the clinical risk assessment process. He said she was part of the senior management team when the risk assessment tool was chosen. He could not remember her raising concerns at meetings of the local board or with him and she had direct access to the director of mental health.

6.44 The director of operations arranged for a check to be made of the local board minutes for 2007, 2008 and 2009. There was no record of psychologist 2 raising any concerns. We saw statistics from the NHS Information Centre for Health and Social Care on suicide and undetermined injury for the years 2005 to 2009. The figures for the CTP and the North East Lincolnshire Unitary Authority (NELUA) were consistently lower than the national average except for 2008 when they were marginally[14] higher. The figures for 2010 are expected to be available between January and March 2012.

6.45 The director of operations told us in writing that it was explained to psychologist 2 at the time that the lone worker policy was felt to be more relevant to assessing, avoiding and alerting situations where staff are prevented from leaving a room or a property. He told us that the expertise of the police would be called on in a hostage situation. He told us that the CTP previously provided training in the prevention of violence and aggression

[14] In 2008 - CTP 9.17, NELUA 9.25, England 7.98 per 100,000 population

to other mental health and learning disability services using the SCIP[15] programme. NAViGO continues to take a lead with a training programme which is accredited by the British Institute for Learning Disabilities and follows Department of Health guidelines.

6.46 Mental health services have transferred to new purpose-built facilities since Mr A's care and treatment. There are two units of 10 beds, six beds in an enhanced care unit and 10 beds for the older people's service. The director of operations told us the new lodges provide a more homely, less clinical and high quality environment. A new model of acute care ensures that care is provided in people's own homes as much as possible, avoiding the stark distinction between inpatient and community care. We did not visit the treatment facilities but the director of operations told us that they have been accredited by the Royal College of Psychiatrists' AIMS[16] scheme as excellent and that the previous facilities were also accredited at the highest level, despite the poorer environment.

Findings

6.47 Psychologist 2 raised significant concerns about safety and security in the mental health service retrospectively but she had not previously put them in writing. The director of operations told us he had discussed with psychologist 2 the relevance of the lone worker policy in preventing hostage situations. He did not remember her raising other concerns and there was no record in the minutes of the local board that she had raised them there. Consultant psychiatrist 1 had no particular retrospective concerns.

6.48 The suicide rate for North East Lincolnshire was consistently lower than the national average except for a marginally higher rate in 2008.

6.49 The organisation was and is taking a lead in the provision of accredited training in the prevention of violence and aggression.

6.50 Mental health services have moved to new purpose-built accommodation. Both the old and the new facilities have been highly accredited by the Royal College of Psychiatrists.

[15] Strategies for Crisis Intervention and Prevention
[16] Accreditation for inpatient mental health services

6.51 NAViGO's new model of acute care focuses on the provision of care in people's homes as much as possible, reducing the previous distinction between inpatient and community care.

Comment

6.52 ***Psychologist 2 expressed significant concerns retrospectively about safety, security and risk assessment in the inpatient service but she did not put them in writing before the incident of 2009 and there was no evidence she had raised them at local board meetings. However, some of her retrospective comments appeared to reflect her previous experience at Rampton Hospital which is a high secure facility with a largely different inpatient population from that of a local general mental health service.***

6.53 ***However, we found evidence that, whilst risk assessment processes were not reliable at the time, the CTP was aware of the importance of the lone worker policy in protecting staff; the suicide rate was usually low; the CTP was taking a lead on training in the prevention of violence and aggression and the physical environment had been highly accredited.***

6.54 ***The new acute facilities and model of care should provide a more appropriate balance of inpatient and community care.***

Conclusion

6.55 As NAViGO has been enhancing risk management processes and redesigning the model of acute care, we have not identified any specific concerns about safety and security that need to be addressed. The evidence points to a reputation for good practice in the provision of training and a high quality environment.

7. Records management

7.1 The terms of reference require us to investigate how Mr A's care and treatment corresponded with obligations and relevant guidance on records management and how local policies and practices addressed this guidance. We touch on these issues elsewhere, but we summarise our findings and comments briefly here.

Findings

7.2 The CTP's records management policy has been in place since January 2005. This policy summarises statutory obligations and relevant legislation as well as local policy and practice.

7.3 At the time of Mr A's care and treatment the CTP was using multiple paper files in separate areas and information on different electronic records.

7.4 We did not request copies of electronic records for Mr A from the CTP, but we saw a printout of the GP electronic records.

7.5 Nursing and medical records were integrated on the same pages in Mr A's case file.

7.6 The case notes showed no discussion within the MDT of the uncertainty about Mr A's presentation.

7.7 Psychologist 1 did not record in Mr A's case file that she had seen him and he was not logged onto the psychology system.

7.8 Psychologists 1 and 2 strongly objected to the record made in Mr A's file about his contact with psychologist 1.

7.9 Psychologist 1's notes about Mr A were partly illegible, undated and under a different name. The notes were not intended to be used as a permanent record and did not reflect the standard of her records in the psychology files.

7.10 The SHO did not record the conversation he had with the older people's team.

7.11 CPA and risk management documentation was used but was incomplete.

7.12 Discharge communications were inconsistent and did not fully reflect the plans noted in the main clinical records.

7.13 Nursing staff recorded the dates of one-to-one sessions with Mr A but it was not always clear from the main entry in the notes what had been discussed.

7.14 Medical staff did not write up the two occasions when nursing staff recorded their concerns about Mr A's physical health.

7.15 We saw no record from the A&E department of Mr A's visit on 7 July and no outcome of the ECG on the same day.

7.16 There was a signature sheet in the ward file for staff to print their names with a sample signature in Mr A's file but only some of the nursing staff used it.

7.17 There was no reliable link between a section 136 assessment and the case file of a service user if they were not admitted at the time.

7.18 We saw no record of Mr A's final missed outpatient appointment or of any decision to discharge him from the service.

7.19 Psychologist 2 objected to the audit of a sample of psychology case notes as part of the CTP's internal investigation, by someone who was not a psychologist, because of assurances given by psychology staff about confidentiality and because of the sensitivity of the content of the records. The audit was undertaken to check the general standard of record keeping.

7.20 Local, national and professional guidelines support shared clinical records with information for service users about limits on confidentiality. Records may need to be accessed to manage the service.

7.21 Paper records are now either integrated or located in the same place and all teams use the MARACIS electronic database except for the Improving Access to Psychological Treatment (IAPT) services, which will be included by April 2012.

Comment

7.22 The CTP's records management policy covers all key areas of records management and sets out the purpose and indicators of good practice. It is in line with national requirements and explains the statutory framework in clear and accessible language. It clarifies the requirements for managing records in all formats.

7.23 The problems we found stemmed partly from the traditional separation between records held by different services, which has been a feature of health services everywhere, and partly from the failure of staff to record some of their actions and observations relating to Mr A, which is not unusual. These difficulties are often identified when adverse events are investigated. We hope that by sharing our findings staff will better understand the importance of accurate records, including risk, CPA and discharge communications.

7.24 The CTP and NAViGO impressed us with their achievements in integrating paper records and implementing a single electronic records system.

Conclusion

7.25 The standard of Mr A's paper records was generally good but with some significant gaps. Multiple separate records systems in use at the time prevented a clear overview of Mr A's care and treatment but the benefits of integrated paper and electronic records are already apparent within the service.

8. Internal referral policies and procedures

8.1 In this section we consider the referral process for three relevant services and how this was managed for Mr A. We look at the psychology service, the alcohol service and the older people's service.

8.2 Requests were also made by the MDT for blood tests, an MRI scan and an EEG examination and Mr A was taken to the adjacent A&E department when he reported shooting pains in his left arm. We considered these interventions in the section on diagnosis and treatment above.

8.3 SHO2 also noted that Mr A had been referred to a tissue viability specialist during his first admission. Mr A had a problem with his feet. There was no further mention in the records of this referral or its outcome.

8.4 We asked the director of operations about the CTP's internal referral policies at the time of Mr A's treatment. He told us there had previously been a system of written referrals between teams that did not help the service user, in his view. So the CTP removed the requirement for written internal referrals and people moved through the service by direct approach from the care coordinator. He recalled writing that there would be no internal referrals and teams would simply discuss what decisions to make.

Psychology service

8.5 In this section we examine the process for accessing the psychology service and the way this was handled for Mr A.

8.6 We examined what was happening in relation to psychology in some detail in view of the CTP's principle of direct contact instead of internal referrals, as outlined in paragraph 8.4 above.

8.7 We heard conflicting accounts of principles and practice within the psychology service and about what happened to Mr A. We set out some of these conflicting statements as they were given to us. We do not comment on the veracity of each statement but draw our conclusions on the balance of probabilities.

Evidence

8.8 Psychologist 2 wrote and circulated a leaflet in 2004 called "*How to refer to mental health care at the psychology consultancy Grimsby*". Psychologist 2 gave us a copy of this leaflet which described the work of the department, the types of problems that could be dealt with, and the roles of the psychologists. It said all referrals should be sent to the psychology consultancy marked for the attention of a particular psychologist. It said all referred patients would be sent a problem checklist and an acceptance slip and first appointments would be given when these documents were returned. The leaflet was not dated and did not indicate that it had been adopted formally as CTP policy.

8.9 We asked psychologist 2, who was head of psychology at the time of Mr A's treatment, about the system for referrals to psychology. She told us "*there is a very straightforward and clear referral pathway to psychology*". She said she, the psychiatrists and the director of mental health had a meeting in the spring of 2007 about the referral process and the introduction of a referral form, which would be the only alternative to a referral letter. Psychologist 2 told us about a similar meeting early in 2008 about referring appropriate cases and the limitations on service delivery.

8.10 Psychologist 2 told us a draft of a revised leaflet was introduced at a further meeting with psychiatrists and the director of operations on 9 April 2009. This leaflet was then redrafted and we have seen two similar versions entitled "*How to refer to adult mental health psychology at the psychology consultancy Grimsby*". One version was dated August 2009 in the electronic heading and the other had no date. Both versions outlined the nature of psychological therapy, the types of treatment offered by the department and the types of problems that could be dealt with. Both versions said all patients referred would be sent a problem check list and consent slip and that first appointments would be given when these documents were returned. The dated version said "*please make sure the referral form/letter has been completed*" and the undated version said "*please make sure the referral form has been completed*'.

8.11 The director of operations said the psychology service *"always sat slightly outside of everything else that we did."* He said he did not know of an internal referral policy held by the psychology service. He recalled that the leaflet was revised and reissued to reduce the number of inappropriate referrals by clarifying the types of cases to refer and the information required. We do not doubt that the meetings mentioned by psychologist 2

took place but we have seen no record of what was agreed at the meetings. We heard different views from psychologist 2 and the director of operations about the status of the revised leaflet and whether it was intended as guidance or policy. In any case, the revision was introduced in the year after Mr A's contact with the service.

8.12 Psychologist 2 told us:

> *"…every time somebody tried to refer inappropriately we would say we need that in writing…There was a very smooth process where the referrals would come in to the office, my PA would have a look at them first. If there was a question about was this an appropriate referral she would come to me…Then the referral would be logged on the computer…* [My PA] *would then send out a psychological problem questionnaire…There would also be a consent slip…and only when it came back to psychology would the referral be activated…Sometimes we just got the consent form back…If it was my person, I would then look in my diary ... and send out a letter for a first appointment. So every stage was fully paper worked."*

8.13 We asked psychologist 2 if this system of written referrals was in use when Mr A was in touch with the CTP and she said "*It was totally in use"*. We asked her if most people observed the process at the time. She told us:

> *"If they didn't observe it, it would be slung back. One exception would be if a colleague…came up and said, 'Could you have a 'quick look' at so-and-so. I'm thinking of referring to psychology, what do you think?' We'd then toddle along and see the person and come back and say, 'Yes, very suitable, there seems to be a background of trauma, wants to be worked with'. Or, 'This is very straightforward. If one of the nurses worked with this person would you like me to support and supervise?' which I did quite a lot."*
>
> *"…It would be informal and I would then be talking to the person whose case it was: should this person be referred, shouldn't they be referred. It saved a lot of unnecessary referrals. Very often they ended up being referred but they would then not be seen until the paperwork was straightened out."*

8.14 The director of operations told us that a psychologist normally picked up referrals to psychology at a ward meeting. He said he assumed psychologist 1 would have picked up

most people without a formal referral by spending time on the ward. This also gave her the opportunity to provide psychological input to the MDT.

8.15 He said consultant psychiatrists could also make a request by letter or email but the idea of the psychologist attending the meeting or ward round was to speed up the process and to make sure the psychology department was picking up the right referrals. He said there was a clear process of referral letters being logged on the system in the psychology department. He expected that if a psychologist had seen someone and wanted to see them again, they would have been logged as if a letter had come in.

8.16 We heard varied accounts of which meetings psychologist 1 attended about inpatients so we have used 'ward meeting' as a general term, as the specific title and function of the meeting was not directly relevant to our investigation.

8.17 Psychologist 1 told the CTP's internal investigation panel that referrals were made verbally on the ward, in meetings or by telephone, by fax or by letter and the process was ad hoc. In an amendment to the notes of her interview, she said she had checked with psychologist 2 after her interview and understood there was a referral form that was rarely used. She also said "*Very seldom was there a paper based request"*. Psychologist 1 gave us a copy of the notes of her interview with the CTP which included more amendments than appeared in the copy given to us by the CTP. One of these additional amendments said: "*To the best of my knowledge no forms nor an official system exists for referrals."* Psychologist 1 told us later in writing that this only applied to consultant psychiatrist 1. She explained that consultant psychiatrist 1 and another psychiatrist operated different systems and ward staff sometimes made telephone referrals.

8.18 Ward staff told the CTP's internal investigation panel that referrals to psychology were made by letter, form or telephone and feedback was usually verbal.

8.19 Consultant psychiatrist 1 told us it was normal practice for him to ask psychologist 1 in a weekly meeting to assess someone. He said he had never made a written referral to psychologist 1 because he could discuss cases directly with her. He said there was a consensus that written referrals were not necessary. He explained that psychologist 1 would carry out an assessment and might decide to work with someone over several weeks, including post-discharge, all as a result of the initial verbal request.

8.20 Psychologist 1 told us that consultant psychiatrist 1 usually made verbal requests for her to see someone on the ward, whereas another consultant psychiatrist always made written referrals. She showed us figures she had submitted to the CTP in December 2009 of the use of referral letters and verbal requests to meet with a service user on the ward. Of 24 requests from consultant psychiatrist 1, 17 were verbal requests only. For another psychiatrist all 6 of their requests were referral letters.

8.21 Psychologist 1 said she sometimes asked consultant psychiatrist 1 to follow up his verbal request with a written referral but he rarely did so. She said she usually received requests informally at a meeting and made her own list of the people she was asked to see. She said she found the process of "*referring in a meeting*" confusing as names, addresses and other vital information was missing. She said she only usually met consultant psychiatrist 1 during crowded team meetings. She was not always given specific information about the individuals or told why she needed to see them, nor did she have time to ask ward staff or to look at the ward case file before she met someone.

8.22 Psychologist 1 explained to us in writing that she:

> *"fell into the trap of responding to the requests and not questioning initially, as I assumed that it was the way things had always been done. It was a grey area because I was more concerned about the client than the process."*

She also told us she did not agree that consultant psychiatrist 1 could discuss cases directly with her as they usually met during crowded team meetings.

8.23 We asked psychologist 1 when an individual would be logged onto the psychology system following a verbal request. She said this would be done after she had carried out a formal assessment and there was sufficient information to open a file. She said it was preferable to have a written referral but she would carry out an assessment and treat people without this in order to provide a service.

8.24 We asked psychologist 2 about feedback from psychologists to psychiatrists. She explained that feedback might be given by bumping into a colleague in the corridor or in a written report. She said "*Sometimes an informal word might be all that was needed*". We asked if psychologists provided feedback by writing in the main case notes while the person was on the ward. Psychologist 2 told us that psychology notes were kept

separately. She said that if a psychologist was working on the ward they should write in the ward file that they had seen the person. She said *"If something needed to be flagged up, that's the place to flag it up"*. Psychologist 2 told us that sometimes the ward file was not available and there was nobody to speak to "*but you should definitely record the fact that you had been on the ward and seen the patient"*.

8.25 We asked the director of operations about feedback from psychologists to the MDT. He said he asked the psychologists in November 2007 always to make a note in the main ward file that they were involved with that person. He had no record of how he had made the request. Psychologist 2 told us that the director of operations was not involved with the psychology service in November 2007. However, the director of operations told us that if a psychologist decided there was no need to see someone again they should record the decision making process in the ward notes.

8.26 Psychologist 1 told the CTP's internal investigation panel that there was no standard practice after she had seen someone and she was never told she should provide feedback to anyone. She said sometimes she would be asked, sometimes she would give feedback at a meeting and sometimes she would find a member of the ward staff to give feedback to. She said her feedback was usually verbal until she was asked in the autumn of 2008 to write in the ward file after seeing someone. She said there appeared to be no procedure to let colleagues know what was happening but she would normally tell ward staff if she wanted to see someone again.

8.27 Psychologist 1 emphasised to us that she was given no induction for her new role with inpatients. She told us she did not understand the ward procedures. She has insisted she was not told originally that she needed to write in the ward case file. She said that when she was eventually told to write her appointments into the ward diary and a summary of what she had done in the ward file, she found this really helpful.

8.28 Consultant psychiatrist 1 told us that there were communication problems with the psychology department because they kept separate records. He said he normally received verbal feedback from psychologist 1 but she sometimes brought a letter from psychologist 2 about an individual that psychologist 1 had seen. He also received written reports from psychologist 1. He could not remember if she ever recorded in the ward file that she had seen someone.

8.29 Psychologist 1 told us psychologist 2 wrote to consultant 1 twice on her behalf - when she disagreed with a discharge and when she had been asking for a written referral for an individual because she was concerned about the seriousness of their problems.

8.30 Psychologist 1 told us she would give feedback to consultant psychiatrist 1 if she saw him but she did not usually have time to seek him out. Otherwise she might give feedback to another member of staff or she might be asked at a meeting. Psychologist 1 told us there was no standard process for her to be included in MDT meetings; she did not always know about them; was not always able to attend and did not always receive any minutes.

8.31 Psychologist 1 told the CTP's internal investigation panel she had a heavy workload and found it difficult to fit in the work on the ward. She told the panel she was seeing 17 people a week as part of her main job and some needed 1½ hour sessions. Psychologist 2 told us there were staffing difficulties with two psychologists on long term sick leave. Psychologist 1 told us she had agreed informally with psychologist 2 that she would provide some input to the wards and other duties so that psychologist 2 would be free to attend external meetings about the reorganisation of the service. Psychologist 1 felt they were both overworked. She said she was tacitly expected to do two full time jobs. She told us her main post within the psychology department was fulltime and she could only fit in work with inpatients when her other clients did not turn up. She said that she and psychologist 2 were the only psychologists working in adult mental health and the department had a waiting list of 400.

8.32 We asked the director of operations what he recalled about psychologist 1's workload. He told us the psychology department had more referrals than they could cope with and no system to prioritise or manage a waiting list. Psychologist 2 told us in writing there was a system based on the length of time on the waiting list and/or urgency but it had been overwhelmed by the discrepancy between staffing levels and the number of referrals. She said: "*beyond a certain level of inundation prioritising becomes impossible - there is nothing to prioritise.*"

8.33 Psychologist 1 told us she was drawn into the additional work informally and discussed the workload frequently with psychologist 2 who did her best to support her. It was agreed her clinical priorities were danger to others, danger to self, unstable

presentations and normal post traumatic stress disorder (PTSD) in that order. She said they had asked for more staff but new posts were allocated to other departments.

8.34 We asked psychologist 1 how much time she spent on the wards. She said she could not quantify this as it depended on other people not turning up for treatment. We understand that psychologist 1 was asked to see seven people on the day she was asked to see Mr A. We did not establish if this was a common weekly number of requests.

8.35 We approached the British Psychological Society for advice on appropriate caseloads for psychologists. They told us they do not have any formal policy on caseload numbers or time allocated to other professional activities. This is because posts vary and benchmark recommendations would restrict the potential to develop posts in line with the changing needs of services. They advise that all professional aspects of a post are represented in the job description and in weekly or monthly job plans. We understand that 16 one-hour contact sessions a week, as well as related meetings and paperwork, would represent a fulltime post for a band 8A psychologist.

8.36 We asked psychologist 1 if there was a difference between the client groups she saw as inpatients or outpatients. She said they had similar problems and she was used to the client group, having previously worked with prisoners with acute mental health problems.

8.37 The only reference to the psychology service in Mr A's case notes was at his clinical review on 2 July 2008 with consultant psychiatrist 1, the staff grade doctor, SHO2 and two nurses. SHO2 recorded: "*Mr A was assessed by* [psychologist 1] *and no psychological features* [or factors?] *noted*". There was no other reference to any communication between the clinical team and the psychologist either before or after this note and no record of any discussion within the MDT about the feedback. Psychologist 1 told us she was not aware of the entry in the case notes at the time and it was not based on anything she had said.

8.38 Consultant psychiatrist 1 told us he had asked psychologist 1 to assess Mr A during one of his regular ward meetings. We asked him what he wanted psychologist 1 to do. He said:

> *"I would like the problems sorted out with any psychological issue which could justify the clinical presentation and another question was about management and follow-up."*

Psychologist 1 told us she did not recall consultant psychiatrist 1 putting a request as clearly as this, as he usually just asked her to see someone after discussing aspects of the case with other staff in the meeting. She said this could be very confusing "*hence the need for written referrals*".

8.39 Consultant psychiatrist 1 said he mentioned the organic problem and we asked what he expected psychologist 1 to do about the organic problem. He said:

> "*I couldn't suggest to her because she is a psychologist and the structure was also that she has access to her boss, a forensic psychologist. Many times I observed that she received some advice from her supervisor or she discussed it.*"

8.40 Consultant psychiatrist 1 could not recall what information he gave psychologist 1 about Mr A but he said he would have expected her to read the relevant documentation in the case file. He did not specifically ask her to carry out a cognitive examination.

8.41 We asked consultant psychiatrist 1 how he would have obtained a neuropsychological opinion or psychometric analysis. He told us he expected psychologist 1 to have some psychometric skill but he did not ask her for that. We asked if he wanted to know about Mr A's cognitive state. He said:

> "*I would like to know everything…to cover this kind of presentation from a psychological point of view. I left it in her hands to do this investigation.*"

8.42 The director of operations explained in writing that two neuropsychologists working in the acute trust were employed by the mental health service and were based in the same building so psychologist 1 would have been able to access advice. He told us the need for neuropsychological advice was rare and would not have warranted a firm

procedure. He said the CTP would have been able to arrange for specialist advice or tests if it was needed. Psychologist 2 told us that neuropsychological testing would need to be supervised by the neuropsychologist working in the acute trust. She said there was no referral pathway between the mental health service and the acute trust but she would have "*tried to twist the arm"* of the neuropsychologist who may not have been able to do the assessment. She said that otherwise she could have recommended and facilitated an external referral to be funded by the CTP.

8.43 Psychologist 1 told the CTP's internal investigation panel she could not recall how she was given the request to see Mr A or why she was asked to see him. She said in many cases she was not told why a member of staff wanted her to see someone and she had to identify the reasons in a first interview to determine whether a full assessment would be needed.

8.44 Consultant psychiatrist 1 told us he could remember a very short conversation with psychologist 1 when he asked for feedback about Mr A and she said "*alcohol problem, no follow-up with the psychologist"*. He said the conversation was one-to-one with psychologist 1 in his office as other staff were often unable to get to the meetings. We asked if he thought this feedback was odd. He said "*not necessarily*". He said he knew Mr A appeared to have relapsed into drinking after the death of a family member and psychologist 1 told him there was an alcohol problem but she had not detected any others. He said he asked her about post-traumatic stress disorder (PTSD) and she said there was none. Psychologist 1 told us she did not have this conversation with consultant psychiatrist 1, but if she had, she would have said she needed to see him again. She told us: "*there certainly was PTSD*".

8.45 SHO2 wrote the note about the feedback in Mr A's case file at the start of his record of the clinical review on 2 July. Consultant psychiatrist 1 told us the note was recorded at his own request as SHO2 was not with him at the time of the feedback.

8.46 We asked consultant psychiatrist 1 if psychologist 1 ever came back to him about Mr A or if they ever discussed him again. He said they did not discuss him again because psychologist 1 had said there were no psychological problems and there was no need for follow-up. He explained that psychologist 1 was involved with further discussion in ward rounds with other clients, especially those with PTSD, and would say she was still involved with someone.

8.47 Psychologist 1 explained to the CTP's internal investigation panel that she wanted to see Mr A again to carry out a full assessment and thought she had said so to ward staff. In an amendment to the notes of her interview, she said that she would have attempted to see him again but thought he had been discharged without her being consulted. She said she was not always consulted about discharges and started to keep a diary of people whom she had been asked to see but who were discharged before she could see them.

8.48 Psychologist 1 told us it was not possible to make arrangements in advance to see someone again because of her workload. She would go to the ward when she had time, for example when one of her other patients failed to attend. We asked psychologist 1 what she did when she was expecting to see someone again but found they had been discharged. She said she told ward staff she had expected the person to be there and would like to have been told they had been discharged. Later, in 2009, she started her diary of these discharges.

8.49 Psychologist 1 found three pages of handwritten notes in her crisis home treatment file during the CTP's internal investigation. These notes were undated, had a different first name and a similar surname, but included information relevant to Mr A. Psychologist 2 wrote in an email to the director of operations three weeks after the incident of 2009:

> "*We found some notes that* [psychologist 1] *made on 2 July 2008. It had been misfiled under* [another name] *but definitely refers to our man. The notes show that far from pronouncing 'no psychological factors' it queries memory problems and dangerousness and shows an intention to do further work on these, only then he left the ward…there was no formal referral for assessment therefore no file existed, mis-named or not."*

Psychologist 1 told us these notes were not misfiled but were kept in the file in case they were needed again. She said she kept the notes because she found the person they related to had been discharged and the notes indicated that the person had memory problems.

8.50 The notes were partly illegible and were typed up during the CTP's internal investigation. The surname at the top of the notes was similar to Mr A's name but the first name was completely different. The notes clearly related to Mr A, with specific details about his background and history. They also referred to the voices telling Mr A to kill someone that started at his sister-in law's funeral and which were not under control, the

knife, his past drinking problem and recent memory problems. This matched the information already recorded in Mr A's ward file. Psychologist 1's notes said Mr A had been unemployed for two months but did not mention his strokes. Her notes said:

> *"? Dangerous voices/himself – would like to say no, but doesn't know if voices took over not sure losing time…can come back but not sure when leaves. Ward needs mobile number."*

8.51 Psychologist 1 confirmed to the CTP's internal investigation that these were the only notes she made about Mr A. She said she made them while she was interviewing Mr A and they represented the beginning of a process rather than an assessment. She said they were a preliminary set of notes from which she could start to develop a clearer assessment, formulation and treatment plan. She said later stages would be based on much more structured work with the individual, but that could not be started until she had some idea of the case.

8.52 The director of operations told us he believed these notes were rough notes psychologist 1 made for herself that were not part of a formal assessment. He said if she did not intend to see Mr A again she should have written a brief summary in the ward file and could have destroyed the notes. If there was to be a further piece of work the notes should have been used to write up a proper record of the meeting. He said he could hardly believe the notes represented her normal standard of record keeping and felt the CTP needed to look at some of her other files.

8.53 The CTP audited record keeping in the psychology department as part of the internal investigation and concluded the standard was acceptable and psychologist 1's records were generally of a high standard. We will return to the audit of the psychology records in the section on the CTP's internal investigation below.

8.54 The CTP received information three times from psychologist 1 about what she could recall about Mr A. There appeared to be inconsistencies in these accounts but the CTP concluded that she had not assessed Mr A as dangerous but that she believed further psychological assessment was needed based on Mr A's history and that this assessment did not take place.

8.55 However, psychologist 1 told us she believed that she may not have interviewed Mr A at any time. She explained that she had seen pictures of Mr A before she found her notes and did not interview the man in the picture. She remembered a thin man with glasses and dark hair but did not remember anything that linked her to Mr A. Psychologist 1 pointed out the differences between the name at the top of her notes and Mr A's name. She said the possibility that the notes did not refer to AM did not appear to have been considered by the CTP during their internal investigation.

8.56 Psychologist 1 told us that the CTP assumed she had seen Mr A and that she told the CTP she had had nothing to do with him. We found no corroboration that she said this to the CTP. Psychologist 1 prepared a written response to the CTP in August 2009 after seeing extracts of their draft report and she showed us a statement she prepared for the CTP in December 2009. Both documents appeared to confirm several times that she had indeed seen Mr A and wanted to see him again. Neither document suggested she had not seen him.

8.57 Psychologist 1 told us she remembered telling someone on the ward that she wanted to see the man she had interviewed again but by the time she went back to see him he had been discharged. She said she gave no other feedback about him because she just wanted to see him again and there was no other relevant feedback to give at the time.

8.58 NAViGO has confirmed that no patient with the name on psychologist 1's notes has been registered with the mental health service.

8.59 We asked psychologist 2 what happened in Mr A's case. She said:

> *"As far as I've understood it,* [psychologist 1] *was sitting in on the crisis team meeting as part of support of psychiatry – it wasn't her day job, she was standing in for* [a colleague] *who was on long-term sick – and she was asked to have a look at, I think it was seven people that day, including Mr A. He wasn't flagged up as anything particularly urgent…So* [psychologist 1] *went round and briefly checked on various people, wrote a few notes. I think four or five of the people she saw that day were sent a written referral, so they got on our books. Mr A wasn't, so he wasn't followed up on because there wasn't a referral."*

8.60 We asked psychologist 2 if Mr A fitted into the 'quick look' that she described and she said "*Yes*". We said it then went no further and she said: "*That's right. It wasn't taken any further by psychiatry.*"

8.61 We asked psychologist 2 how she would describe psychologist 1's notes. She said they were unofficial. If the case had then been referred, psychologist 1 would have had something to base her initial assessment on or to jog her memory. Psychologist 2 did not think there was a common format for the initial look as it was not part of the formal system.

8.62 We asked psychologist 2 what she would expect to happen to these notes if psychologist 1 heard no more and there was no written referral. She said the notes could have been thrown away as they were not part of any official structure. If there had been a referral, psychologist 2 would have expected the notes to be incorporated into the patient file with a note "*written pre-referral*".

8.63 Psychologist 2 explained to us that a 'quick look' would not have included an assessment. It would have been a general conversation about the person's problems, whether they would like to be referred to psychology and what they would like to work on. An assessment would be more formal to look in-depth at the problem, history and background using various techniques depending on the individual psychologist.

> *"Obviously in Mr A's case, had his referral come in it would have been flagged up as problematic because of the strokes and because of the kind of strokes they were. The cerebellar one, for instance, could easily have affected his thinking, his cognition and emotion."*

8.64 Psychologist 2 confirmed to us in writing that there was a system of written referrals, used by other referrers, which included the use of a referral form. She explained that only the psychology office could log someone onto the system and this was done when the written referral came in. She said referrals were not made by telephone. She said it was counter to explicit psychology policy and "*administratively impossible*" for psychologist 1 to carry out an assessment and treat someone without a written referral. She clarified that a 'quick look' was only to see if a referral was needed. It was not an alternative to a written referral but was something people might use prior to the formal system. Psychologist 2 also told us there was "*not the slightest possibility*" that

psychologist 1 did not know at the time that she should record in the main case notes that she had seen someone on the ward.

8.65 Both psychologist 1 and psychologist 2 made the point that a psychologist would not have said "*no psychological features* (or factors)" and expressed concerns about inaccurate reports about the psychology service being written in main case notes.

8.66 During the early stages of the CTP's internal investigation psychologist 2 said Mr A would have needed a neuropsychological assessment. She said in an email to the director of operations three weeks after the incident of 2009: "*the complexity of symptoms goes way beyond what any 'ordinary' psychologist would tackle*".

8.67 Psychologist 2 told us she would not have expected psychologist 1 to have carried out the psychometric assessment that a neuropsychologist would do. She said she would have identified the need for this when she was supervising psychologist 1. We asked psychologist 2 what she would expect a psychologist to do if they were worried about someone but heard no more. She said she would expect them to go back to the psychiatrist who made the request:

> *"I'm not sure how worried* [psychologist 1] *was. I'm not sure she would have understood the significance of the strokes because that's out of her field. That would have been picked up by me."*

8.68 Psychologist 1 told us in writing that she was obviously concerned because she kept her notes. She said there was always plenty to discuss in supervision and, as an assessment had not been started, there was little point giving this case a higher priority than some others. She said Mr A would have been discussed after a full assessment.

8.69 As mentioned previously, psychologist 1 felt she had relevant experience for the inpatient client group. She told us that during an initial interview she might identify the need for further assessment by a neuropsychologist. As the experienced neuropsychologist was usually too busy, psychologist 1 would arrange for a trainee psychologist from the older people's service to carry out a neuropsychological assessment under supervision.

8.70 We asked psychologist 1 about her own supervision. She told us she had weekly supervision with psychologist 2 and felt it was essential because of the nature of the client

group. She said she would discuss cases she had concerns about or whose presentations she did not understand. She also looked for information from the internet and in books. She found psychologist 2 helpful and accessible.

8.71 The director of operations told us he would have relied on psychologist 2 to advise him about the skills needed in a post. Psychologist 1's post had been upgraded from band 7 to band 8A at psychologist 2's request. Psychologist 2 told us that band 7 was the usual grade for newly qualified psychologists and this would be reviewed after a period of preceptorship.

8.72 The CTP had previously arranged an external review of the psychology service after psychology staff expressed concerns about a colleague and about supervisory arrangements. The report of December 2007 said the psychology service appeared to be isolated in the CTP. The recommendations covered internal relationships and communications in the psychology service; clinical supervision records; links with other parts of the CTP such as clinical service managers and human resources; professional development plans; lines of accountability; managerial supervision and appointment processes. The director of operations told us significant managerial changes were made as a result of this review with psychologists becoming accountable to managers in the areas where they worked.

8.73 Another external review of the psychology service was carried out after the CTP's internal investigation. As a result, a full time senior psychologist now works exclusively in acute services for adults. The leadership of the psychology service has changed with the new post holder reporting to the director of operations. Psychological assessment and intervention are accessed using robust procedures set out in a new policy with a clear process for referrals, feedback and record keeping. There has been a fundamental change to psychology records which are now on the MARACIS single electronic record system. Consultant psychiatrist 1 told us how pleased he was with the benefits of access to full records.

Findings

8.74 There was a general principle of direct contact between CTP services instead of internal referrals when Mr A was involved with the CTP.

8.75 We heard conflicting accounts about the referral pathway for psychology and about what happened in Mr A's case.

8.76 The usual route into the psychology service was a referral by letter or form. Referrers could also choose to make a personal approach for a 'quick look' to see if someone needed to be referred. Written referrals were expected for a full assessment and the 'quick look' was only expected to be used prior to the formal written system. Only the administrator could log people onto the psychology system.

8.77 The 2004 version of the psychology leaflet indicated the need for a written referral and the two later versions requested a referral letter or form but none of the leaflets mentioned the 'quick look' and none indicated they had been adopted formally as CTP policy. The two later versions were written after the time of Mr A's contact with the CTP.

8.78 Two meetings were held, prior to Mr A's involvement with the CTP, at which referrals to psychology and the limited capacity of the service were discussed with medical staff. We have seen no record of what was agreed at the meetings.

8.79 Most requests by consultant psychiatrist 1 for psychologist 1 to see inpatients were direct and verbal. They each told us that psychologist 1 usually assessed and treated consultant psychiatrist 1's patients without a written referral. Psychologist 2 said this was "*administratively impossible*".

8.80 Consultant psychiatrist 1 asked psychologist 1 to see Mr A. He made the request during a meeting and did not specify what he wanted psychologist 1 to do or consider for Mr A.

8.81 Psychologist 1 saw Mr A and wrote notes about him which were partly illegible, undated and under a different name. The notes were not intended to be used as a permanent record and did not reflect the standard of her records in the psychology files.

8.82 The notes were kept in the psychology department but Mr A was not logged onto the psychology system, no file was made for him and psychologist 1 did not see him again.

8.83 Psychologist 1 told us she may not have seen Mr A at all. We found no corroboration that she said this to the CTP. Her notes clearly referred to Mr A and the other name was not registered with the service.

8.84 Consultant psychiatrist 1 said psychologist 1 told him she did not need to see Mr A again. Psychologist 1 was adamant she did not speak to consultant psychiatrist 1 after she saw the person she interviewed.

8.85 Psychologist 1 said she wanted to see this person again and thought she had said so to ward staff, but did not see him again, probably because he had already been discharged. Consultant psychiatrist 1 said if she wanted to see him again, she would have done so of her own accord. Psychologist 2 said psychologist 1 did not see Mr A again because there was no written referral.

8.86 There was an expectation that psychologists would record in the ward file that they had seen someone. Psychologist 1 did not record in Mr A's ward file that she had seen him. She said she did not know about this expectation until the autumn of 2008. Psychologist 2 said there was "*not the slightest possibility*" that she did not know this at the time. There was no requirement for any other written feedback.

8.87 SHO2 wrote a note in the ward file later at consultant psychiatrist 1's request that psychologist 1 had assessed Mr A and found "*no psychological features*". There was no record of any discussion within the MDT about the feedback reported by consultant psychiatrist 1. Psychologist 1 did not know about the entry in the ward file and said it was not based on anything she had said.

8.88 Psychologists 1 and 2 objected strongly to other staff writing in ward files about the psychology service.

8.89 Psychologist 1 was not involved in any discussion about Mr A's discharge.

8.90 Psychologist 1 normally worked with patients in the community and said she had no induction for her additional role with inpatients.

8.91 The psychology department was overwhelmed with referrals. Psychologist 1 had a heavy workload while covering for an absent colleague in addition to her usual role. She felt she had relevant experience for the client group and had good access to supervision.

8.92 Psychologist 1 said she could only see inpatients when one of her other clients failed to attend. She said she often had little information before she saw someone on the ward. She said she was often not invited to MDT meetings or did not have time to attend.

8.93 There was no formal provision of neuropsychological advice as it was rarely needed but it could be arranged by the CTP.

8.94 NAViGO now has a dedicated psychologist for acute services and a new psychology lead. There is a new psychology policy describing a clear process for referrals and feedback with a summary of all sessions recorded directly onto MARACIS.

Comment

8.95 ***Concern was expressed to us about the length of this section of our report in relation to the time spent by the psychology service with Mr A. We accept that this might appear disproportionate but there are three main reasons for this level of scrutiny. Firstly, we felt Mr A should have received a full psychological assessment and we wanted to understand why this did not happen. Secondly, we were asked to interview psychologists 1 and 2. Thirdly, we received conflicting evidence about what did happen and we felt this required closer examination.***

8.96 ***The terms 'referral' and 'assessment' have been used by various people in various ways in relation to the psychology service. These terms have a specific and logical meaning within the psychology service but we recognise that they have been used broadly by others, resulting in considerable misunderstanding. We do not believe there has been an intention to mislead by such broad use.***

8.97 ***Much has been made of whether there was a referral to psychology. Psychologist 2 insisted there was no referral for Mr A and indeed there was no written referral. However she described two initial approaches to us, a written referral and a verbal request for a 'quick look'. We accept that psychologist 2***

expected a 'quick look' to be used only to decide if a referral was needed and she expected it to be followed by a written referral. We also accept that other referrers made written referrals and used the referral form. However, despite the circulation of a leaflet by psychologist 2 in 2004 and meetings with psychiatrists, we saw no evidence that the CTP had formally adopted a policy of written referrals to psychology. In fact there was a general principle of direct contact between CTP services instead of written referrals and we found that a 'quick look' was consultant psychiatrist 1's usual route into the psychology service for his inpatients. Furthermore, according to consultant psychiatrist 1 and psychologist1, it was usual to proceed from a 'quick look' to a full assessment and intervention for his inpatients without a written referral, albeit reluctantly on psychologist1's part.

8.98 *The psychologist was not required to provide written feedback after a written referral and assessment or after a 'quick look'. However, the director of operations and psychologist 2 expected there to be a record, preferably in the main case notes, that the psychologist had seen someone on the ward. Psychologist 1 said she was not made aware of this at the time.*

8.99 *A 'quick look' may have been intended as an optional pre-stage to a written referral but we conclude that a 'quick look' was being used for some of consultant psychiatrist 1's inpatients as an alternative referral process. As such it was at best unreliable and at worst unfit for purpose, as in Mr A's case. The process was deficient at every stage for Mr A. No record was made of the request to see Mr A; there was no evidence of the information given to the psychologist about Mr A's history and problems; the psychiatrist asked no specific questions; the psychologist's initial notes were unidentifiable and illegible; Mr A was not logged in the psychology department's system and the psychologist made no record in Mr A's case notes. The only record was a brief note recorded by the junior doctor on behalf of consultant psychiatrist 1 and there was no evidence of any discussion within the MDT about the feedback reported by consultant psychiatrist 1.*

8.100 *Psychologist 1 claims she may not have seen Mr A at all but the notes she made were clearly about Mr A and his particular history and we have concluded that she did see Mr A. She said the only feedback she might have given to ward staff was that she wanted to see him again. Consultant psychiatrist 1 recalls her saying she did*

not need to see him again and he asked SHO2 to make a record in the ward file. We could not reconcile these incompatible accounts.

8.101 *Whatever happened, the individual and systemic failings are clear. The psychiatrist should have asked specific questions, but he left them to the psychologist. The psychologist should have sought clarification of Mr A's history and problems but she found the meetings confusing and she was pressed for time. The psychologist's notes were unidentifiable and illegible but they were not intended as a permanent record. The psychologist should have made her own record in the main case file, but she said she did not know about this requirement at the time. The psychiatrist should have had a discussion with the psychologist and pressed her for written confirmation if he thought she had no concerns, but he was not expecting written feedback. The psychologist should have been invited to a discussion about Mr A's discharge but the MDT thought she had no concerns and she often did not have time to attend the meetings. The psychologist should have spoken directly to the psychiatrist and to psychologist 2 if she was concerned that Mr A had been discharged, but she was not always consulted about discharges. The process was too reliant on personal contact and initiative and could not protect the service user or staff from individual failings.*

8.102 *Psychologist 1 and psychologist 2 objected strongly to the wording of feedback about the psychology service written by other staff in the main case notes for Mr A and others. The entry about Mr A was made at the request of consultant psychiatrist 1, based on what he said he was told by psychologist 1. We accept that the words in Mr A's file would not have been used by a psychologist but this was one of the unfortunate consequences of psychologist 1 not writing in the file herself. Psychologist 1 disputed the validity of this entry but we could not establish the facts of what passed between her and consultant psychiatrist 1.*

8.103 *We do not know what psychologist 1 knew about Mr A before she saw him. We do not know if she had spoken to ward staff about him or looked through his case notes or if she knew about his second stroke, but she did not mention his strokes in her notes. She could only have known about the second stroke if she had seen the MRI report or the first discharge letter as there was no other mention of it in the ward file.*

8.104 *Psychologist 2 often identified issues from written referrals that she needed to address in supervision. However, if psychologist 1 could see someone for an initial interview and proceed to a full assessment without a written referral, there might be no trigger for her supervisor to review the case unless psychologist 1 raised concerns herself. In Mr A's case she did not raise concerns with her supervisor about the initial interview, or about the lack of a written referral or about his discharge. We conclude that she was not sufficiently concerned to mention it.*

8.105 *A neuropsychological assessment would have helped to identify any underlying cognitive problems or intellectual impairment. It would have identified more clearly the relative importance of Mr A's cerebrovascular disease and any alcohol-related cognitive change. Certainly, an assessment of frontal executive function would have been helpful, although it does not always identify the difficulties as much as expected. We cannot know what the outcome would have been or if it would have made any difference. Even so, the psychologist should have been involved in a multidisciplinary discussion of diagnosis and risk, and possibly in exploring the nature of the reported voices, and this would have been useful in reaching a better understanding of Mr A.*

8.106 *We were concerned about the difficulty psychologist 1 appeared to have managing her workload with her additional role on the wards. She said she discussed it with psychologist 2 who was her supervisor and manager and who appeared to be aware of the situation. Despite the high waiting list and staff absences, psychologist 2 had a professional responsibility to support psychologist 1 in prioritising her workload and to discuss any unmanageable difficulties with her own line manager. Psychologist 2 did discuss the high waiting list with the director of mental health and meetings were held with referrers in an attempt to manage this and ensure all referrals were appropriate. We could not establish why the situation appeared to have become so difficult for psychologist 1.*

8.107 *We were also concerned that psychologist 1 said she had no induction for her additional role with inpatients and she did not know about the requirement to record in the ward file that she had seen someone, despite psychologist 2's assertion that she must have known. There was no reasonable way to validate these claims but we feel it was their joint responsibility to ensure psychologist 1 understood the*

requirements of her work on the wards, especially as it was a new environment for her.

8.108 ***We were pleased to hear that psychology services have changed significantly in structure, leadership and processes. Psychology is now integrated into all services and psychologists record in the integrated electronic record. It is to everyone's advantage that the new psychology policy sets out a clear process for referrals and feedback, and that psychologists are now using MARACIS.***

Conclusion

8.109 The process used to access the psychology service for Mr A was not fit for purpose. We could not establish exactly what happened between the psychology service and the MDT, despite interviewing staff and examining documentary evidence, but the opportunity for a full psychological assessment was missed. We do not know if this would have made any difference in the longer term but it would have increased the MDT's understanding of Mr A.

8.110 The separateness of the psychology service, both perceived and actual, put everyone at a disadvantage and we were pleased that structural and procedural changes to the psychology service have since been made.

Recommendations

R5 NAViGO should ensure psychologists' case loads and job plans are appropriate and reviewed on a regular basis. [see paragraphs 8.31, 8.106]

R6 NAViGO should ensure there is a robust system of supervision for clinical staff which does not rely on the supervisee raising their own concerns about individual cases. Supervisors should identify some cases for discussion and ensure that all cases are discussed within an agreed timescale. [see paragraphs 8.70, 8.104]

Alcohol service

8.111 Mr A had a well-documented history of excessive drinking. The CTP summarised his consumption for their internal investigation. His GP records indicated he drank 80 units of alcohol a week in August 1994; 40 units in April 1999; 12 units in June 2004; 105 units in July 2005. He then he saw an alcohol counsellor at the GP surgery and reduced from over 60 units to 16 units in August 2005. His acute hospital records indicated he drank 44 units in January 2007 and 40 in July 2007. When Mr A was admitted to the mental health ward in June 2008 he said he had a problem with alcohol two years previously and now drank no more than 14 units a week but the out-of-hours GP service said he had been drinking up to 86 pints per week. His GP records indicated he drank 16 units a week in November 2008 and after the incident of 2009 Mr A said he drank 56 units a week.

8.112 We now consider the process of referral to the specialist alcohol service provided at The Junction[17].

Evidence

8.113 We were told there was no written policy for accessing substance misuse services at The Junction but NAViGO is currently finalising a policy.

8.114 The CTP's internal investigation report said it was normal to encourage people to self refer to The Junction rather than to make a referral on their behalf. One of the ward staff told the CTP's internal investigation panel they could also ask Junction staff to see someone on the ward.

8.115 The director of operations told us that Junction staff now attend the inpatient ward at set points during the week, so they can meet service users and discuss cases with ward staff.

8.116 We asked the director of operations about the availability of a dual diagnosis service[18]. He told us that there were (and are) staff in the drug and alcohol service with a special interest in mental health and mental health staff with a special interest in

[17] Drug and Alcohol service provided by Rotherham, Doncaster and South Humber NHS Foundation Trust

[18] Dual diagnosis services are for people with both mental health and substance misuse problems.

substance misuse who operate as a virtual team rather than a separate structure. There is a referral pathway to a consultant psychiatrist based within the mental health service.

8.117 Mr A was advised to stop drinking at his clinical review on 11 June and it was noted that "*alcohol issues were addressed*". Staff agreed to refer him to the alcohol service at The Junction "*with view to discharge*". This had changed to "*stop alcohol and visit Junction*" at his discharge on 16 June. At his second admission on 19 June Mr A was advised not to drink alcohol while on medication. There was no further record of any discussion about the need to stop drinking.

8.118 We asked the director of operations how long Mr A could have stayed with The Junction if he had used their service. He said he believed they would have been less assertive in their follow-up than the mental health service. They were likely to have discharged Mr A when he disengaged rather than taking any further action.

8.119 Consultant psychiatrist 1 told us he thought Mr A had alcohol dependency rather than mental illness and that was why he was encouraged to visit The Junction. We asked consultant psychiatrist 1 if he considered seeking advice on dual diagnosis, or whether someone from the alcohol service should see Mr A on the ward about his drinking. He said Mr A had no second diagnosis but he did not think such a service was available and Mr A would have had to refer himself to The Junction. Consultant psychiatrist 1 said there are still problems with people being accepted by The Junction.

8.120 We asked consultant psychiatrist 1 about Mr A's chances of recovery from alcohol dependence. He said he was fairly optimistic because Mr A said he could maintain abstinence, he was compliant with his treatment, he engaged with staff and he reported an improvement.

Findings

8.121 The CTP had no written policy on referrals to substance misuse services and it was normal to encourage people to refer themselves but NAViGO is currently finalising a policy.

8.122 Dual diagnosis specialists were available but consultant psychiatrist 1 did not seek advice because he did not consider Mr A had a second diagnosis.

8.123 Staff suggested that Mr A should be referred to The Junction towards the end of his first admission, but he was not. He was advised to visit The Junction on the day he was discharged. This was not followed up or mentioned during his second admission. We saw no evidence Mr A was offered help to use alcohol services and no evidence he contacted The Junction.

8.124 Consultant psychiatrist 1 did not think he could ask someone from the alcohol service to visit the ward but one of the ward staff told the CTP's internal investigation panel they could request this. Junction staff now visit the ward regularly but consultant psychiatrist 1 felt there were still problems with the acceptance of some clients.

8.125 Consultant psychiatrist 1 was optimistic about Mr A's chances of recovery from alcohol dependence.

Comment

8.126 ***We could not find out why suggestions about the alcohol service were not followed up and what options existed for involving staff from The Junction. Consultant psychiatrist 1 thought Mr A had to contact the service but ward staff believed he could be referred and Junction staff could have visited him on the ward. Nobody pursued this.***

8.127 ***It is exceptionally difficult to motivate someone who is reluctant to acknowledge their drinking to use services. However, arrangements should have been made for someone from the alcohol service to meet Mr A on the ward to try to improve his motivation to seek support about drinking. This might not have changed the outcome, particularly if he did not understand the role of alcohol in his presentation. However it would have increased the chance of him using these services and of being monitored and supported in the community for longer.***

8.128 ***It might have taken Mr A a long time to accept the need for treatment for his heavy drinking. A mental health care coordinator could have provided a level of support and containment in the meantime.***

8.129 ***The current arrangement for substance misuse specialists to see inpatient service users and discuss cases at set times is commendable. However, problems may still exist between mental health and alcohol services, as in many parts of the country. The new policy for accessing drug and alcohol services will need to ensure clear criteria for mental health service users and a mechanism to resolve problems between the services.***

Conclusion

8.130 Alcohol was a significant cause of Mr A's psychosocial problems. He might not have engaged with the alcohol service of his own accord but he could have been supported to access the service while he was an inpatient and as part of a coordinated care plan in the community, as he had done with the help of his GP a few years earlier. His drinking probably played an important role in his relatively empty days and a big shift in his situation would have been needed to bring about any real change.

Recommendations

R7 The CTP should ensure drug and alcohol services are commissioned to provide an appropriate and accessible service for mental health service users, including inpatients, with a clear mechanism to resolve problems between the services. [see paragraphs 8.119, 8.126]

R8 NAViGO should finalise a policy for accessing drug and alcohol services, to ensure there are clear criteria for accepting mental health service users and to establish a clear route for discussion of problems between the services. [see paragraphs 8.119, 8.126]

Older people's service

8.131 The older people's service saw people with organic mental health problems, such as physical brain damage, regardless of their age. In this section we examine Mr A's referral to the older people's service.

Evidence

8.132 There was no formal referral process between services within the CTP. The director of operations told us it worked more smoothly with older people's services than with the psychology service, because of direct contact between the teams. He said there was no need for letters between consultants and the small size of the organisation allowed decisions to be made quickly in face-to-face discussions and recorded on the joint electronic system. He said the best place for an individual was generally agreed in a straightforward way. A senior manager would resolve any problems.

8.133 SHO2 wrote to the older people's CMHT on 9 June 2008. The letter outlined Mr A's history and recent tests and asked the team to review him and possibly take over his management. A handwritten note on the older people's copy of this letter said: "*13/6/08 Spoke to* [SHO2] '*referral made too soon' not stable on ward. Looking at alcohol problems*". There was no evidence of this conversation or of any other feedback in Mr A's case notes.

8.134 There was no indication on this letter of who was to receive a copy. We found a copy in the adult CMHT file but no evidence a copy was received by the GP.

8.135 At Mr A's clinical review on 16 June staff noted "*Contact Elderly for outpatient follow-up*" and "*the doctor requested a full elderly assessment in the community*". The notification of discharge form of 16 June (completed by SHO2 and signed by consultant psychiatrist 1) said "*to see the Community Consultant (Elderly Team) on 29/06/08*" but there was no further reference to this appointment or to the referral in Mr A's case notes and it was not mentioned on his CPA care plan or in the full discharge letter. Mr A missed this appointment but he was back on the ward by then. The older people's service had no file for Mr A.

8.136 Consultant psychiatrist 1 told us he referred Mr A to the older people's service because they deal with organic changes in the brain. We asked consultant psychiatrist 1 if he could have asked a colleague from the older people's team to see Mr A on the ward. He said he could have done this but he asked specifically for assessment and care coordination by the older people's CMHT with a view to a transfer to their service. Consultant psychiatrist 1 said he did not feel care coordination with the adult CMHT was needed because Mr A had no observable signs of psychosis, there were no problems with his behaviour and he was taking his medication.

8.137 Consultant psychiatrist 1 told the CTP's internal investigation that feedback was received from the older people's CMHT that a care coordinator had not been allocated and consultant psychiatrist 1 believed the referral was being processed. He expected Mr A's adult community consultant to deal with the transfer and to know about the referral to the older people's CMHT from the weekly adult CMHT meetings. We do not know if the community consultant knew of this referral and the adult CMHT notes that we saw do not mention it, but there was a copy of the referral letter in the adult CMHT file.

8.138 Consultant psychiatrist 1 told us he received no feedback from the older people's team and, at the time, he did not know about the conversation the SHO had with them. We asked consultant psychiatrist 1 if he felt he needed to find out what was happening with the referral. He told us consultant psychiatrist 2 was responsible for Mr A following his discharge and any letter from the older people's team would be sent to consultant psychiatrist 2. If the community consultant was aware of the referral he, like others, was probably not aware of any outcome.

8.139 We asked consultant psychiatrist 1 why he made a written referral to the older people's team if there was no need for written referrals. He said he makes written referrals to departments which are not part of the adult acute mental health service because he rarely has the chance to speak to them in person. He explained that services are currently going through a process of integration.

Findings

8.140 Mr A was referred by letter to the older people's CMHT, even though the CTP did not require written referrals, because consultant psychiatrist 1 rarely met his colleagues

in the older people's team. The letter resulted in a conversation with SHO2 that was not recorded in Mr A's case notes or fed back to consultant psychiatrist 1, and an appointment with the community consultant in the older people's CMHT that Mr A missed when he was back on the ward.

8.141 After Mr A's readmission neither the referral nor the appointment was mentioned again.

8.142 A decision about this referral would normally have been recorded on the electronic records system. We did not request Mr A's electronic records but the CTP did not discover what happened to the referral when they undertook their internal investigation.

8.143 Consultant psychiatrist 1 did not ask the older people's service to see Mr A on the ward. He wanted them to consider a transfer to their CMHT for care coordination after Mr A was discharged.

8.144 Consultant psychiatrist 1 was not seeking input to Mr A's assessment on the ward and expected feedback about the referral to go to the outpatient consultant.

8.145 There was a copy of the referral to the older people's CMHT in the adult CMHT file but we do not know if the community consultant was aware of it.

Comment

8.146 ***Consultant psychiatrist 1 said he made a written referral to the older people's team because he did not see them often enough to talk to them directly We were not sure what the handwritten note on the copy of referral letter meant. It may have been a message from the older people's CMHT to SHO2 that the referral had been made too soon, or it could have been from SHO2 to the older people's CMHT. The speech marks around the message indicate it was said by SHO2. Either way, the onus appeared to be on consultant psychiatrist 1's team to come back later and yet an appointment seems to have been booked with the community consultant in the older people's team. We saw no other trace of this appointment apart from the note on Mr A's first discharge form.***

8.147 ***Consultant psychiatrist 1 could have sought an opinion from a colleague in the older people's team to assist with diagnosis and a management plan while Mr A was on the ward, especially during his second admission. A month passed between the referral letter of 9 June and Mr A's second discharge on 9 July. A second opinion might have been useful before he was discharged but this was not the intention of the referral. Consultant psychiatrist 1 wanted the older people's service to consider a transfer to their CMHT when Mr A was discharged.***

8.148 ***The decision to transfer to an adult of working age community consultant (consultant psychiatrist 2) and also to an older people's CMHT*** **"does not make sense"**, ***as the CTP's internal investigation report said, especially as consultant psychiatrist 2 may not have known about consultant psychiatrist 1's intention. The usual discharge process from an adult inpatient setting was to transfer to the adult consultant for outpatient follow-up or to the adult CMHT for care coordination. Consultant psychiatrist 1 wanted the older people's CMHT to assess Mr A with a view to taking over his management in the community even though he did not feel Mr A needed input from the adult CMHT. Unfortunately there was no reliable system to sort out these options. Nobody had the full picture.***

Conclusion

8.149 This was a complex case and it was good practice to seek an assessment by the older people's service, which deals routinely with organic brain problems but nothing came of this referral. Nothing in the documentary evidence clarified what happened and the people we interviewed could not explain the failure of this request, despite their efforts to find out. However, the aim of the referral was not to access a specialist opinion to assist with diagnosis and management but to transfer Mr A to the older people's CMHT after he had been discharged. This might have been helpful if it had led to monitoring by a care coordinator but the referral was not pursued.

Recommendation

R9 NAViGO should ensure there are robust systems for adults of working age teams to seek an opinion from the older people's service and for recording the outcome. [see paragraph 8.148]

Overall conclusion on internal referrals

8.150 The MDT was diligent in requesting tests and opinions but did not use the outcomes well. Referrals and requests for an opinion on Mr A were considered or made to eight complementary services. Blood test results were informative about Mr A's heavy drinking but this was not addressed as a key problem. The SHO misinterpreted the MRI scan report which resulted in a faulty referral for the EEG. Consultant psychiatrist 1 disregarded the opinion expressed in the EEG report. Medical staff did not write up the referral to A&E and the case notes contained no A&E report, nor any record of the outcome of the ECG requested by A&E. The outcome of the involvement of the psychologist was not pursued and remains uncertain. The other three: to the older people's, alcohol and tissue viability services, resulted in nothing at all. There was a gap at the heart of the care planning and treatment process.

8.151 We were concerned that the diagnostic uncertainties explored in the sections above were not identified in the case notes. We saw no evidence of direct consultation with colleagues in related specialities. This was a puzzling case and it would have been reasonable for the most experienced clinician to acknowledge this, to seek the opinion of colleagues and other experts, and to question their views if they did not fit the clinical picture.

9. Discharge policy, CPA and post-discharge follow-up

9.1 Here we examine the arrangements for Mr A's discharge and follow-up in the community, including the use of the care programme approach (CPA).

9.2 CPA is the process that mental health services use to coordinate care of people with mental health problems. The concept was introduced in 1991 and in 1999 the national guidance *Effective care coordination in mental health services – modernising the care programme approach* set out arrangements for all adults of working age under the care of secondary mental health services. Revised national guidance was published in March 2008 as *Reviewing the care programme approach* but this would not have been implemented when Mr A was in contact with the CTP.

9.3 The key elements of CPA are:

- systematic arrangements for assessing the health and social care needs of people accepted by specialist mental health services
- a care plan which identifies the health and social care to be provided from a range of sources
- a named care coordinator to keep in touch with the service user and to monitor and coordinate care
- regular reviews and agreed necessary changes to the care plan.

Evidence

9.4 The CTP was using a CPA policy carried over from when the service was part of the Doncaster and South Humber Healthcare NHS Trust. It included a section on discharge and leave planning and a section on people who disengage, although we were told the CTP had no written policy for people who did not attend (DNA).

9.5 The section on discharge planning said in paragraph 9.7.2 that seven-day follow-up could be achieved in a variety of settings but "*must always have been planned and agreed before discharge*".

9.6 The section on people who disengage said in paragraph 10.5.2 that if the care coordinator could not contact a service user who was on standard level CPA and at no known risk, they should offer another appointment and inform the GP. We were told the usual practice for people who missed appointments was that a further appointment would result from the first DNA and a second DNA would prompt the consultant to offer another appointment or discharge.

9.7 The CTP's *Adult Protection Policy* has been in place since August 2003. A vulnerable adult is defined in section 3 as a person aged 18 years and over who is or may be *"in need of community care services by reason of mental or other disability, age or illness; unable to take care of himself; unable to protect himself against significant harm or serious exploitation."* Mr A did not fit these criteria and was not identified as a vulnerable adult by the CTP.

9.8 The CTP's internal investigation found that Mr A's CPA paperwork was not always fully completed and the care plans and discharge plans were particularly poor. We set out some of the evidence in this section.

9.9 Mr A was first discharged on 16 June 2008 on standard CPA. His keyworker and care coordinator was identified as consultant psychiatrist 2, the community consultant for adults of working age. The discharge form said he would see the community consultant in the older people's team on 29 June 2008. Mr A attended the ward for follow-up two days later, in accordance with CTP policy. He said he heard overwhelming voices and he felt mentally unwell. He was reassessed and he was not readmitted. He was given telephone numbers to call for support. The plan said the adult community consultant would see him soon and an appointment with consultant psychiatrist 2 was offered by letter for 12 August 2008.

9.10 Mr A was readmitted on 19 June 2008. The full discharge letter for 16 June was written on 20 June and gave the plan as: visit The Junction and an outpatient appointment with consultant psychiatrist 2 in two to three weeks' time (although it was booked for 12 August). The letter mentioned the stroke in 2004 and the repeat MRI showing the left stroke. There was no mention of the concerns expressed on 18 June, or of Mr A's readmission on 19 June, or of the referral to the older people's CMHT, or of the appointment with the community consultant in the older people's team on 29 June.

9.11 Mr A was taken to visit a local MIND group during his second admission. Staff recorded that he did not appear very interested but he said he would like to go again. Mr A's care plan did not refer to the MIND group and there was no evidence of another visit.

9.12 On 27 June 2008 ward staff noted Mr A was "*ready and looking forward to discharge*". At his clinical review with consultant psychiatrist 1 on 2 July, SHO2 recorded that Mr A was worried about going out and did not know what would happen. After the review ward staff recorded that Mr A was hoping to be discharged but was happy to stay as long as the doctor felt was necessary. Consultant psychiatrist 1 told us Mr A wanted to be discharged earlier than his date of discharge which was a week later.

9.13 On 7 July 2008 a member of staff spent one-to-one time with Mr A and recorded that he was happy to be going on leave for a few days but there was no record of where Mr A would be or what he would do.

9.14 Mr A returned from leave two days later and said it had gone well. He was discharged that day on standard CPA. He said he planned to return to his job and staff intended to fax his GP in London, although there was no information in the case notes about the job, the GP in London or any contact details for Mr A. His CPA care plan named his keyworker as the ward and did not name a care coordinator. The CPA care plan said Mr A would be contacted by phone to arrange his seven-day follow-up. No phone number was recorded for Mr A but his mother's number was on the front sheet and he had given permission to contact her when he was first admitted. Mr A did not sign this plan. Mr A did sign a separate acute services care plan. This said: "*To contact and confirm on Thursday Mr A's whereabouts for his seven days follow-up*" and gave his mother's name and number.

9.15 The discharge notification form gave Mr A's diagnosis as organic hallucinosis, said he was discharged home and mentioned seven-day follow-up by the crisis home treatment team, but did not mention the move to London, drinking, strokes, his referral to the older people's CMHT or the outpatient appointment.

9.16 The full discharge letter was written on 14 July 2008. The letter gave Mr A's diagnosis as "*organic psychosis – hallucinosis*", listed his medication, the circumstances of his admission and outlined his progress on the ward. The letter explained that Mr A agreed he could control himself and was not going to act on the voices; there was no evidence of

Mr A responding to voices and he admitted the voices had decreased considerably and the medication was working. The letter said Mr A was moving to a job in London and would have seven-day follow-up but there was no mention of the MRI findings, the second stroke, his drinking, the referral to the older people's CMHT or the outpatient appointment.

9.17 The plan was to contact Mr A on Thursday 10 July 2008 for his seven-day follow-up and this was noted in the east sector access meeting minutes. There was no record of any attempt to contact Mr A until Monday 14 July when ward staff tried to ring him but did not leave a message on the answering machine because they were not sure the number was correct. They did not record the number they tried but the care plan said contact was to be via Mr A's mother. In the section of the CPA document for seven-day follow-up there was an unsigned and undated note that ward staff tried several times to ring Mr A.

9.18 In fact Mr A's parents were desperate to contact him at this stage but only discovered he had been in hospital after he was discharged. When they rang the hospital they were told he had been discharged but they were unable to obtain any more information.

9.19 Consultant psychiatrist 1 told us that although he referred Mr A to the older people's CMHT, he did not feel Mr A needed care coordination from the adult CMHT because he had no signs of psychosis, there were no problems on the ward and Mr A was taking his medication.

9.20 A letter was sent to Mr A's original address on 16 July 2008 offering an outpatient appointment for 12 August. It was returned unopened marked "*refused*" on 24 July.

9.21 In the meantime Mr A walked into the police station on 21 July 2008 for a third time, carrying a knife and saying voices were telling him to kill someone. He was taken to the mental health ward via A&E, assessed under section 136 of the Mental Health Act and discharged. The EDT[19] report gave Mr A's address as "*no fixed abode*", with no phone number and noted he had left the shared house he had been living in and was now living in guest houses in Cleethorpes. The A&E form showed Mr A's previous address and a different mobile number from that recorded on 19 June 2008. The assessing team noted Mr A was an inpatient from 3 to 16 June 2008 but we saw no evidence of any check on his follow-up or on the address held by the CTP. Mr A had missed his seven-day follow-up by then and staff

[19] Emergency duty team

thought he had moved to London. We consider this assessment further in the section below on the use of the Mental Health Act.

9.22 When Mr A missed his outpatient appointment on 12 August 2008 (not having received the letter), a new appointment was sent on 14 August for 7 October. This letter was returned unopened marked "*addressee has gone away*" on 26 August. On 28 August staff checked the address with the GP practice. Staff tried to ring Mr A before the appointment on 7 October but they had only his previous telephone number. So he did not know about this appointment either. Staff checked the address with the GP practice again on 17 October and sent an appointment for 23 December – but to a different house number. Again the letter was returned unopened marked "*not known at this address*".

9.23 Mr A told the GP practice on 31 October 2008 he was living in a Salvation Army hostel in Grimsby but the outpatient team were not aware of this.

9.24 On 18 November 2008 Mr A saw his GP who carried out a mental health review and noted Mr A was taking his medication, his symptoms were under control, he was not having hallucinations and he was not carrying a knife. The GP felt Mr A did not need regular follow-up unless he relapsed. He noted Mr A had a keyworker in the Salvation Army and his drinking was controlled. Mr A was still taking aripiprazole (antipsychotic) and epilim chrono (anticonvulsant).

9.25 Mr A's final failed appointment with consultant psychiatrist 2 was on 23 December 2008 and as before, he did not know about it. There was no record in his case notes that he did not attend, no evidence of any attempt by the CTP to contact Mr A or his GP and no evidence of any decision to discharge him from the mental health service.

9.26 Mr A collected his repeat prescription from the GP practice in March 2009, having last seen his GP in November 2008. Police found boxes containing some of the medication after the incident. He had not taken all of it and had not requested a repeat prescription.

9.27 The CTP's internal investigation noted that while there was a local requirement for GPs to maintain a register of patients with severe mental illness (SMI) and to review these patients at least every 15 months, Mr A's presentation would not have indicated inclusion on the SMI register. There was also no requirement to act if patients failed to request

repeat prescriptions for antipsychotic medication, although this is now included in the prescribing standards for primary care.

9.28 The director of operations told us that mental health teams, including consultants, are now based in GP surgeries. A named mental health worker is assigned to each GP with a team manager for each group of practices.

9.29 Consultant psychiatrist 1 told us he felt communication between inpatient and outpatient consultants was still weak and it was difficult to find time for an effective handover. He was also concerned about links with the home treatment team.

9.30 We asked Mr A when he moved from his original address. He said he stayed with friends when he came out of hospital, and was on the streets until a friend told him to contact the Salvation Army who found him a room in their hostel in Grimsby. He had a keyworker at the Salvation Army who helped him get his flat in Grimsby, sometime after Christmas 2008. He did not go back to his original address because his landlord phoned while he was in hospital and said he owed £500, but he did not tell the ward staff he was homeless. Mr A told us he did go to London with a friend for a few days after he was discharged. They stayed in hostels while they looked for work.

9.31 We asked Mr A why he did not contact his family and he said he did not think about it while he was looking for work. He also said he did not contact the hospital because "*I thought I was doing ok*". He said he was not expecting to hear from them and did not know they were arranging an appointment. When he went to his previous address to collect his belongings there was mail for him but no letter from the hospital. He said that if there had been a letter he would have rung the hospital to say why he had not come to his appointment. He also told us that he later gained a forklift truck operator's certificate which required assessment in maths and English.

9.32 Mr A's parents told us they tried to find out where he was by contacting pubs near to where he had been living. They wrote to his landlord and sent money for his train fare but heard nothing back. When they contacted the police they were told he was in hospital but not the reason. They were told the police could not trace him and it was believed he had gone to London. When they contacted the hospital they were told he had been discharged. Mr A eventually got in touch at Christmas 2008. His parents persuaded him to stay with them for a family birthday a few months later when they found he was fine but

quieter than usual. They said the murder of the young woman was a terrible shock as he had never been violent towards anyone in the past.

9.33 A CPA working group has been established and the CPA policy and documentation have been refreshed and ratified. CPA audits have been undertaken.

9.34 NAViGO has a new discharge policy describing clear procedures for planned discharges. The policy provides strategies to enhance engagement, and guidance on dealing with disengagement to stop people losing contact with mental health services.

Findings

9.35 Mr A's first discharge from inpatient care was on standard CPA with consultant psychiatrist 2 named as his care coordinator. For his second discharge he was also on standard CPA but no care coordinator was identified. The plan was for outpatient follow-up by consultant psychiatrist 2. Mr A did not meet the vulnerable adult criteria.

9.36 The admission forms included sections for discharge arrangements but these were not used.

9.37 The discharge plans varied between the records, documents and letters. There was no consistency about what was expected to happen next.

9.38 Communications for the first discharge mentioned the referral to the older people's team on the discharge form but not in the full discharge letter. The letter covered diagnosis, medication, progress on the ward, the stroke in 2004 and the repeat MRI showing the left stroke, the history of excessive drinking and willingness to stop. The letter did not mention the readmission.

9.39 Communications for the second discharge covered diagnosis, medication and progress on the ward but did not mention the second stroke, drinking, the referral to the older people's CMHT or the outpatient appointment with consultant psychiatrist 2.

9.40 Consultant psychiatrist 2 may not have known about the referral to the older people's CMHT and there was no known outcome.

9.41 Mr A's visit to the MIND group was not followed up. It was not included in his care plan and there was no evidence of another visit to the group.

9.42 There was no record in the case notes of discussion with Mr A about where he would be and what he would be doing while on leave before his second discharge.

9.43 There was no evidence of prior discussion with Mr A about his second discharge, apart from a note by ward staff a week earlier that he was hoping to be discharged but was happy to stay as long as the doctor felt was necessary.

9.44 Contact details for Mr A were not clarified and his seven-day follow-up was not arranged before his second discharge in accordance with CTP policy. Mr A had already had a call from his landlord about the rent by the time he was discharged but he did not tell ward staff he was now homeless.

9.45 Staff did not try to contact Mr A's mother when they could not trace him, although they had her telephone number. Mr A's parents rang the hospital after he had been discharged but no link appears to have been made with the staff trying to trace him.

9.46 Section 136 assessors did not pass on Mr A's new phone number and the fact that he was of no fixed address on 21 July 2008 to staff arranging his follow-up and outpatient appointments.

9.47 Staff tried to contact Mr A before his second booked outpatient appointment but did not have his new address or phone number.

9.48 Staff did not follow the policy for people who disengage and inform the GP that they were unable to contact Mr A.

9.49 Outpatient staff were not aware of Mr A's move to the Salvation Army hostel. They had checked his address with the GP practice two weeks before and were told they had the same address.

9.50 Mr A's GP carried out a mental health review on 18 November 2008 and felt he did not need regular follow-up unless he relapsed. Mr A was still taking antipsychotic and anticonvulsant medication.

9.51 The CTP did not note Mr A's third failed outpatient appointment in December 2008 and did not record any decision to discharge him from the mental health service.

9.52 The CTP did not notify the GP that Mr A had been discharged from the mental health service and did not know if the GP was happy to take over his care.

9.53 Mr A collected his repeat prescription in March 2009 but did not take all of it and did not request a repeat prescription.

9.54 There was no requirement for GPs to act if people did not request repeat prescriptions for antipsychotic medication, although this has now been addressed via the prescribing standards for primary care.

9.55 Mental health teams are now based in GP surgeries with clear arrangements for liaison.

9.56 CPA policy and practice has been revised and supported.

9.57 The new discharge policy describes clear procedures for planned discharges and strategies for dealing with people who do not attend.

Comment

9.58 ***The CTP's internal report found CPA assessments lacked personal history and did not focus adequately on social factors such as accommodation, social inclusion and employment. Little appeared to be known about Mr A other than the current clinical picture. The CTP concluded that care plans and discharge plans were "little more than standard templates with minor modifications".***

9.59 ***We agree with the CTP. There was no genuine engagement with Mr A and he did not tell staff he was homeless when he was discharged from the inpatient ward the second time.***

9.60 ***We found the communications for the first discharge were appropriate, although with some inconsistencies, but we found the communications for the second***

discharge were inadequate. They focused on diagnosis, medication and progress on the ward, but did not mention the second stroke, drinking, the referral to the older people's CMHT or the outpatient appointment with consultant psychiatrist 2. These points were mentioned in the communications after the first discharge but they were serious omissions after the second discharge.

9.61 *Mr A could have stayed in hospital longer before his second discharge while further investigations were carried out, including an assessment by the older people's service but these investigations could have been undertaken in the community. We cannot tell if a longer stay would have made any difference to his discharge plan as Mr A was taking his medication and the MDT thought it had reduced his symptoms.*

9.62 *We were not convinced Mr A wanted to be discharged early from his second admission. Although ward staff noted his comment after his review on 2 July 2008 that he was hoping to be discharged and consultant psychiatrist 1 recalled this, SHO2 did not record it during the review. Indeed SHO2 noted that Mr A said he was worried about going out and did not know what would happen. He may already have known that he was not returning to his previous accommodation.*

9.63 *We cannot be sure how Mr A felt about either of his two discharges and the situation he was returning to in the community but he seemed happy in hospital because he enjoyed the company and was comfortable with the inpatient environment. He may have actively worked towards being admitted.*

9.64 *We do not know what Mr A conveyed to staff about his plans to return to work and to go to London at his second discharge, or about the existence of a GP in London. Mr A told us he was already homeless before he was discharged although he did not tell staff about this. He told us he went to London for a few days to look for work.*

9.65 *The CTP's internal investigation found that when staff failed to complete the seven-day follow-up, a home visit should have been arranged and if that was unsuccessful Mr A should have been referred to the assertive outreach team. The CTP found there was no agreed policy on whether this should have been escalated to the inpatient or outpatient consultant. The CTP concluded that the MDT's understanding*

Mr A was planning to go to London may have resulted in giving up on the seven-day follow-up.

9.66 *The CTP also concluded that the complexity of Mr A's condition and the number of risk factors meant it would have been prudent to introduce a care coordinator from adult CMHT to monitor his mental state, compliance with medication and drinking.*

9.67 *We agree that a longer assessment in the community should have been considered with a care coordinator from the CMHT to monitor the relationship between alcohol and Mr A's mental state, and any risk of him carrying an offensive weapon. This might have informed the CMHT about Mr A's presentation in the community better than the assessments in hospital. It might have identified his drinking as a significant component of his presentation and helped to clarify the diagnosis. Mr A did not meet the vulnerable adult criteria and a referral to social care would not have been warranted.*

9.68 *Support to visit a MIND group might also have helped Mr A understand the relationship between his drinking and his presentation, as well as the risks he was running.*

9.69 *We found clear evidence of discharge planning and attempts to arrange seven-day follow-up. The community consultant was supposed to see Mr A as an outpatient. Mr A's discharge plan could hardly have been simpler but its execution was poor. The failed attempts to contact Mr A and the returned letters did not trigger a home visit. An attempted home visit might have prompted alternative strategies to trace Mr A such as an enquiry to the homeless services, contact via the GP (who Mr A was still seeing) or contact via Mr A's mother. The fact that three letters were returned with a clear message that Mr A was no longer at his original address should have prompted a different response.*

9.70 *Mr A said in early June 2008 that he only wanted his mother contacted in an emergency, but he had given permission to contact her when he was admitted and he gave her name and number when he was discharged. In the meantime Mr A's parents were trying hard to get in touch with him and eventually rang the hospital only to be told that he had been discharged. Mr A did not ring them until Christmas 2008. He*

told us he did not think about contacting his parents while he was looking for work. It is a great pity he was out of touch with his supportive family for so long.

9.71 *Mr A should have been followed up more assertively from a psychiatric perspective. However, consultant psychiatrist 1 believed the older people's team were processing the referral despite the lack of evidence for this. The MDT also appeared to think that Mr A's presentation was largely related to drinking and therefore his management plan would be self-referral to alcohol services, although this was not explicit and not in the plan. Nevertheless, Mr A had been prescribed antipsychotic and anticonvulsant medications and in our view the specialist opinion of a consultant psychiatrist and mental health team were important for the GP in deciding how to proceed with his management.*

9.72 *The overall process of discharge planning and follow-up for Mr A was inadequate. There was no evidence of proactive discussion about his discharge; no focus on his home situation; his contact details were not clarified; his seven-day follow-up was not agreed before his second discharge; there was no attempt at a home visit or a referral to the assertive outreach team and his GP was not informed of the failure to contact Mr A. The referral to the older people's CMHT was not pursued, nor was any input arranged from the adult community team, and there was no confirmation in the case notes of his discharge from the outpatient clinic.*

9.73 *The opportunity was missed at the third section 136 assessment to re-establish contact with Mr A and ensure he knew about his outpatient appointment on 12 August 2008. The CTP had no system to inform the GP or the consultants about this assessment. We will consider this further in the section below on the use of the Mental Health Act.*

9.74 *The mental health review Mr A's GP documented was good practice but unfortunately he was given no information about the possible effect of the second stroke. He did not know about the third section 136 assessment or the failed outpatient appointments. He was not told if Mr A had finally been discharged from the mental health service and the CTP did not know if he was happy to take over Mr A's mental health care. The CTP's apparent lack of follow-up must have puzzled the GP. His decision that Mr A did not need regular mental health follow-up was reasonable, based on what he knew at the time.*

9.75 ***The lack of any formal requirement for the GP to review Mr A's antipsychotic medication has been addressed in the local primary care quality standards for prescribing.***

9.76 ***We were pleased to hear about the location of mental health teams, including consultants, in GP surgeries and the assignment of named workers to each GP. These arrangements should make a big difference to understanding and joint working.***

Conclusion

9.77 The discharge and follow-up arrangements for Mr A were inadequate and the CTP lost contact with him. The mental health service should have seen him again to monitor his treatment, his mental state and his risk profile and to encourage him to access the alcohol service and reduce his drinking. Ten and a half months passed between Mr A's last contact with the mental health service and the death of Miss B and her unborn child. We know little about what happened to Mr A during that period except that he was homeless for a while and then he lived in a Salvation Army hostel. His GP thought he was stable in November 2008 and he had moved into his own flat by February 2009. Mr A seemed fine but quieter than usual when he next saw his family.

9.78 Mr A might have attended his first outpatient appointment on 12 August 2008 if he had known about it, but we do not know how long he would have continued to see a psychiatrist, especially if his GP was happy to take over his care. The last opportunity for Mr A to attend an outpatient appointment was on 23 December 2008 but he never received the letter.

9.79 We do not know whether the involvement of a care coordinator from one of the CMHTs would have made any difference. More might have been known about Mr A's mental state, his alcohol consumption and his social situation but it is unlikely the care coordinator would have continued to see Mr A after his GP felt he was stable and not in need of regular follow-up. It is unfortunate that, before the events of 2009, Mr A did not approach the mental health service or go to a police station, as he did just over a year earlier.

9.80 NAViGO and the CTP have been diligent in implementing robust new procedures for CPA and discharge. The CTP would have had a much better chance of staying in touch with Mr A until he was ready for full discharge if these arrangements had been in place earlier.

Recommendation

R10 NAViGO should ensure there are robust links between the inpatient consultants, the home treatment team and the outpatient consultants that allow for consultation and effective handover. [see paragraph 9.29]

10. Use of the Mental Health Act

10.1 In this section we examine the use of the Mental Health Act 1983 to assess Mr A when he went to the police station carrying a knife and saying he was hearing voices telling him to kill someone.

10.2 Section 136 of the Mental Health Act 1983 allows for the removal of a person to a place of safety to enable him to be examined by a doctor and interviewed by an approved mental health practitioner (AMHP) and for any necessary arrangements for his care and treatment to be made.

Evidence

10.3 The CTP had a joint agency protocol with the local authority setting out the arrangements for section 136 of the Mental Health Act.

10.4 This provision was used three times for Mr A in 2008. On the first occasion on 2 June Mr A was detained at a police station under section 136 because he had gone to the police station carrying a knife and saying he was having ideas of self harm and hearing voices telling him to kill people. Consultant psychiatrist 1, another doctor and AMHP1 assessed him and he was admitted to a mental health ward as an informal patient. The second occasion was on 19 June, three days after being discharged and the day after his seven-day follow-up. Mr A went to the police station carrying a knife and saying he was hearing voices telling him to kill someone. This time consultant psychiatrist 3, another doctor and AMHP2 assessed him and readmitted him to a mental health ward.

10.5 Mr A was detained in similar circumstances for the third time on 21 July when he was assessed by consultant psychiatrist 4, another doctor and AMHP2. This time he was not admitted. AMHP2 checked the local authority information system and recorded on the EDT report that she had assessed Mr A several weeks ago and he had been an inpatient from 3 to 16 June 2008. She did not realise she had assessed him on 19 June 2008 when he was readmitted. There was no indication the assessing team were aware of this second admission, or of his discharge on 9 July, or of the failure to make contact with Mr A for his seven-day follow-up, or of the expectation that the police might take action in these circumstances. AMHP2 noted Mr A was of no fixed abode and:

"…all felt Mr A was to some extent exaggerating his symptoms in an attempt to gain admission again. Ward staff held similar opinions. [Consultant psychiatrist 4] *said his claimed symptoms do not fit with any regular mental illness. She is to send a letter via email to Mr A's GP, recommending changes to his medication, which she told Mr A will alleviate his voices, with minimal side effects."*

10.6 There was no evidence in the case notes that a letter was sent to Mr A's GP about the assessment but there were four other records of this third presentation. The A&E adult see and treat form included nursing notes that Mr A was brought in by police under section 136 and referred to the crisis team. The section for medical notes was left blank. The GP record contained a note that Mr A attended A&E on 21 July 2008 but did not say why. This note also said the copy of the A&E report had been deleted and re-entered a year later. There was a copy of the A&E notification letter to the GP in the GP records that was dated a year later. The letter gave minimal information about the attendance on 21 Jul 2008 and said nothing about the section 136 assessment. The letter gave Mr A's address as the flat in Grimsby that he moved to early in 2009. This letter appeared to be the only information the GP received about the events of 21 July 2008. There was also a brief note on the ward report for 21 July 2008 that the EDT assessed Mr A and he was regraded to informal status and discharged.

10.7 Consultant psychiatrist 1 told us he did not think he knew about the section 136 assessment on 21 July 2008 at the time. He confirmed the assessing consultant was not obliged to write a letter if the person was not admitted. The AMHP was responsible for recording the assessment and the outcome. Consultant psychiatrist 1 said that if a letter had been written it would have been sent to the community consultant because Mr A had been discharged from hospital.

10.8 We asked the director of operations about arrangements for recording section 136 assessments. He told us that the EDT was part of a separate organisation at the time of Mr A's assessments. They kept their own notes and would fax or email records to the CTP where they were held in the Mental Health Act office. The director of operations told us that EDT staff are now part of NAViGO so AMHPs' records of section 136 assessments are available on MARACIS as well as a summary of significant information about each service user. NAViGO also has a mechanism to inform consultants and GPs that one of their service users has just had a section 136 assessment that did not result in admission.

10.9 Consultant psychiatrist 2 did write a full letter to Mr A's GP following his section 136 assessment after the incident of 2009.

Findings

10.10 There was no evidence that the consultant psychiatrist who assessed Mr A on 21 July 2008 had access to his mental health records at the time but she had been present at four of the five east sector access meetings when Mr A was mentioned. At these meetings she would have heard about his two admissions and his second discharge when staff needed to contact Mr A to confirm his whereabouts.

10.11 When AMHP2 assessed Mr A 21 July 2008 she checked the local authority information system and knew she had assessed him previously but did not realise that this was on 19 June when he was readmitted. There was no indication on the EDT record of 21 July 2008 that anyone knew about his second admission or the failed seven-day follow-up. There was no evidence of any check that Mr A was still in touch with mental health services, or that the CTP had his current contact details.

10.12 The EDT record of 21 July 2008 did not mention the previous discussion about the possibility of the police taking action if Mr A was found with a knife, but the health staff who saw Mr A would not have known about this without full access to his clinical notes. There was no indication on the EDT record that they reminded Mr A to contact mental health services instead of the police in times of distress.

10.13 We saw no evidence that consultant psychiatrist 4 sent a letter to Mr A's GP, or that the GP was ever informed about Mr A's third presentation with a knife and the subsequent 136 assessment. There was no evidence that consultant psychiatrist 1 or consultant psychiatrist 2 knew about the events of 21 July 2008.

10.14 There is no formal requirement for consultant psychiatrists to record a section 136 assessment, even for someone who is still in touch with mental health services.

10.15 There is no formal requirement for GPs to be informed about section 136 assessments of their patients.

10.16 AMHPs' records of section 136 assessments and summaries of significant information are now included on MARACIS. NAViGO also has a system to inform consultant psychiatrists and GPs about section 136 assessments that did not result in admission.

Comment

10.17 ***We do not know what access the section 136 assessors had to Mr A's mental health records or to what extent they took his history into account when deciding not to admit him. We saw no documentary evidence that they knew this was Mr A's third similar presentation within seven weeks or that staff had been unable to contact Mr A recently for his seven-day follow-up. Nor was there evidence that they were aware of the warning given to Mr A about carrying a knife; the possibility of the police taking action and the advice to contact mental health services instead of the police. The opportunity was missed to tell Mr A that he needed to be in contact with mental health services and would be supported by them, even if he did not need to be admitted.***

10.18 ***Mr A's third section 136 assessment should have triggered a review by one or both of the consultant psychiatrists involved in his care, but they appeared to know nothing about it. We do not know what difference this might have made but some of the short-term gaps in his discharge plan might have been filled, such as re-engagement with mental health services, a review of his risk profile, better information to his GP and support to use alcohol services.***

10.19 ***We understand the AMHP makes the formal record of a section 136 assessment to reflect the joint decision, but it seems odd there is no requirement for the consultant psychiatrist involved to make a note in the clinical records of someone who is a current patient when there is no admission. (If there is an admission, a further psychiatric assessment will be undertaken and recorded in the clinical records by the admitting doctor.) However, NAViGO has significantly improved the process, with the AMHP's report of a section 136 assessment and a summary of significant information visible to staff accessing the electronic records at a later stage. In addition there is now a system to inform consultants and GPs that a service user has just had a section 136 assessment that did not result in admission.***

10.20 ***The previous weaknesses in the management of section 136 assessments will be reflected in many trusts around the country.***

Conclusion

10.21 When Mr A was assessed for a third time under the Mental Health Act, less than two weeks after being discharged, there was no effective system for the assessors to know he had been discharged so recently or that the CTP had been unable to contact him for his seven-day follow-up. To make matters worse, there was no system to tell Mr A's psychiatrists and his GP about the third time he went to a police station with a knife. This meant his risk profile was not reviewed and the opportunity to engage with him again was missed. NAViGO has greatly improved the systems for recording and communicating section 136 assessments.

Recommendations

R11 NAViGO should audit the accessibility, content and timeliness of the summary of significant information about a service user, including 136 assessments, available on MARACIS, to ensure it is available in an emergency and includes appropriate information. [see paragraphs 10.17, 10.19]

R12 NAViGO should audit the mechanism for telling consultant psychiatrists and GPs that one of their service users has had a section 136 assessment that did not result in admission, to ensure it is prompt and robust. [see paragraphs 10.18, 10.19]

11. Interface, communication and joint working

11.1 The terms of reference require us to investigate the interface, communication and joint working between all those involved in assessing Mr A and providing care to meet his mental health, physical health and social needs, including the police and his GP. As we have covered these issues in the sections on care and treatment above, we summarise our findings and comments briefly here.

Findings

11.2 During Mr A's two admissions there was little documentary evidence of discussion within the MDT about his presentation. Significant pieces of information were not shared within the MDT, such as Mr A's shaking hands, two strokes and the conversation between SHO2 and the older people's team.

11.3 There was no documentary evidence of any discussion with colleagues in other specialities, even with those who were asked for their opinion such as the older people's team, the psychologist and the neurophysiologist.

11.4 There was no contact with the alcohol service.

11.5 There was no direct communication between the inpatient and outpatient consultants, particularly in relation to post-discharge care planning.

11.6 There was no clear documentary evidence that the outpatient consultant was aware of the referral to the older people's service.

11.7 Information in the discharge communications was inconsistent and did not include significant pieces of information about risk management and follow-up arrangements.

11.8 No information was passed to Mr A's GP or to his psychiatrists about the third Section 136 assessment or the fact that he was homeless.

11.9 No link was made at the third section 136 assessment on 21 July 2008 with the discussion between the police and CTP staff on 4 July about Mr A's capacity and the warning about carrying an offensive weapon.

11.10 After Mr A's first admission there was no evidence of any communication with his GP while he was on the ward about his background and recent history. There was then no liaison about the failed seven-day follow-up; about the failed outpatient appointments; about any decision to discharge him from mental health services or about whether the GP was happy to take over his mental health care.

11.11 Mr A's address was checked twice with the GP surgery after his second discharge, but outpatient staff did not know about his change of address two weeks later.

11.12 There was no liaison with anyone else about Mr A's whereabouts when staff were unable to contact him.

11.13 There was no contact with Mr A's family or anyone else who knew him about his history and presentation. The opportunity was missed to obtain further information to contribute to his care plan and risk profile.

11.14 Mental health teams are now based in GP surgeries, with a named worker allocated to each GP and a team manager for each group of GP practices.

Comment

11.15 ***It was difficult to find examples of good practice in interface, communication and joint working but there were many examples of poor practice. We were particularly concerned about the lack of communication with the older people's team, the psychologist, the neurophysiologist and the alcohol service.***

11.16 ***Support and supervision of junior medical staff is an important element of communication within the MDT. There were indications that key issues were not discussed, such as the apparent confusion about Mr A's strokes and the telephone conversation with the older people's team. The lack of evidence of reflection in the case notes made us wonder what discussion took place between the consultant and the junior doctors. Clinical supervision should provide an opportunity for the***

management of clinical quality and for learning. In addition, the ability to demonstrate uncertainty and to ask colleagues, including junior colleagues, for their views is a mark of clinical awareness and teaching skills.

11.17 *The discharge letters should have mentioned the need to encourage Mr A to access alcohol services. The GP had arranged for Mr A to receive support to cut down his drinking a few years before, but ward staff might not have known this. That is not to say the GP needed any reminder about Mr A's needs but there was a lack of this sort of liaison between primary and secondary services.*

11.18 *The discharge letters should also have given the GP a clearer view of the risk assessment.*

11.19 *The arrangements now in place for closer liaison between specialist mental health services and GPs should greatly enhance communication and joint working.*

11.20 *It was commendable that staff discussed Mr A's capacity to take responsibility for his own actions with the police. Unfortunately it appeared the police had no accessible record about the warning to Mr A that they could take action if he contacted them again carrying a knife. This was recorded in Mr A's clinical notes but it was unlikely that health staff would have looked at this record when he went to the police station a third time. It is difficult to see how the original joint initiative could have been acted on but we hope MARACIS will facilitate such an initiative in future. Nevertheless, it may not have had any effect on Mr A's behaviour in the longer term, even if it had been actioned in July 2008.*

Conclusion

11.21 Interface, communication and joint working were poor in several directions. Many systems were not robust and these weaknesses allowed individual failings to influence care and treatment more than they should have done. This also affected the way Mr A was followed up but we do not know if it affected the eventual outcome. NAViGO has demonstrated its awareness of the need for improvement by implementing solutions and acknowledging there is more to be done.

Recommendations

R13 NAViGO should ensure documented clinical supervision of junior doctors takes place and that case based discussion and scrutiny by the consultant of medical records and written communications completed by junior doctors are key tools in workplace based assessment. [see paragraph 11.16]

R14 NAViGO should liaise with the local police service to ensure the process for confirming any informal joint agreements on managing people known to both services is robust. These agreements should be flagged up by information systems when any significant event occurs. This is for people not involved with the forensic service or with any other formal joint process. [see paragraph 11.20]

12. Overall conclusions on care and treatment

12.1 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. The independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident. All the same, the investigation will usually find things that could have been done better without necessarily changing the course of events. There are usually lessons to be learned.

12.2 We could not identify a critical single cause that led to the outcome in this case but we have identified concerns about the processes and systems in the mental health service at the time.

12.3 Mr A was in hospital for a total of five weeks but his assessment was incomplete with the result that his clinical picture remained confusing. There was no clear focus on some important aspects, particularly potential damage to his brain, heavy use of alcohol and psychological and neuropsychological factors. Antipsychotic treatment was started the day after he was admitted to hospital with no evidence it was really needed. His case was not discussed with colleagues from other specialties. We were not sure Mr A's treatment could have had any positive effect on his mental health.

12.4 The MDT appeared to know little about Mr A's personal and social situation but felt he had some insight into his behaviour and found him consistently pleasant and compliant. Mr A was not supported and monitored in the community. Discharge arrangements were poor and the CTP lost contact with him when he left hospital but he did not tell them he was homeless. He should have been followed up assertively and encouraged to seek help when he needed it, although he never approached the mental health service of his own accord. He killed Miss B and her unborn child ten and a half months after he was last seen by the mental health service. There were elements of Mr A's care and treatment which could have been much better but we cannot say that this tragedy could have been prevented.

12.5 The CTP and then NAViGO introduced important changes to the structures and systems in mental health services after the internal investigation and their efforts to make significant improvements are commendable.

12.6 We have identified further learning for the organisation from the investigation of Mr A's care and treatment. Our recommendations address this learning but we found no causal link between the learning points and the events of 2009.

13. The CTP's internal investigation

13.1 The terms of reference require us to comment on:

- the conduct and quality of the internal investigation, its ability to identify root causes and the clarity in which these are presented in the internal report
- the strength of the recommendations in the internal report
- the quality of the action plan and the subsequent activities of the Care Trust Plus to effectively implement that plan and the evidence of the audit and review of those actions.

In accordance with the terms of reference, we focus on the CTP's internal investigation of the serious incident of 2009. We do not comment on any subsequent processes.

The conduct and quality of the internal investigation

Evidence

13.2 The CTP's incident reporting policy has been in place since March 2007. It set out requirements for reporting incidents and carrying out investigations. A report of the investigation of a serious incident, including an action plan, was required within eight weeks of the incident. There was no guidance in the policy on the composition of the investigation team but the director or assistant director was identified as having overall responsibility, according to the flowchart on page seven. There was clear guidance on action required after a serious incident and on collecting and storing documentation. There was limited information about the process of investigating serious incidents with a brief outline of the principles of root cause analysis. There was no guidance in the policy on interviewing witnesses but there were two references to the PCT's document 'Investigation of Incidents, Complaints and Claims'. We have not seen this document and understand it is no longer in use and difficult to obtain from the archive.

13.3 The CTP held an internal management review immediately after the incident, and drew up terms of reference for an internal investigation. The investigation team comprised the director of operations, a senior mental health nurse who was also the clinical risk manager, an external professional nursing adviser and an external professional

psychiatric adviser. The CTP also identified a commissioning lead for the internal investigation and established a decision panel to oversee the investigation team. The decision panel comprised the chief executive, the director of performance and service improvement, the director of mental health, the public relations and marketing manager, a non-executive director and an independent medical adviser.

13.4 The investigation team created a timeline of actions taken after the incident with copies of relevant documentation.

13.5 The CTP met the families of Miss B and Mr A and interviewed key people including Mr A's inpatient and outpatient consultants, three nursing staff from the ward, the medical director for primary care, psychologist 1 and Mr A's GP with two practice nurses. Psychologist 2 was not interviewed as part of the internal incident investigation.

13.6 The interview with the GP and the practice nurses appeared to focus on the content of the practice records for Mr A without checking what the practice knew about Mr A's contact with the mental health service or seeking their views on links with the service.

13.7 Psychologist 1 told us she was asked by telephone to attend an informal meeting about the incident. Psychologist 2 told us that psychologist 1 was invited on the day of the interview and had no chance to prepare herself. Psychologist 1 said she received no letter explaining the purpose of the meeting and was not invited to bring a companion. The meeting was not recorded electronically and psychologist 1 said the notes were incomplete and inaccurate and did not represent the answers that she tried to give. She said she was given one day to make amendments.

13.8 The director of operations confirmed that the CTP did not invite interviewees to bring a companion to the interview. He recalled that interviewees were mainly invited by email but the CTP had no record of an email to psychologist 1. He thought she was invited by telephone because it was only at a late stage that her name was linked to the case. The CTP's timeline indicated that the link was confirmed on 30 June 2009 and the interview with psychologist 1 was arranged on 16 July to take place on 20 July 2009, but we saw no confirmation of when she was informed about it. Three nursing staff were interviewed on the same day. All four were interviewed by the director of operations, the external nursing advisor and the clinical risk manger. One nurse was accompanied to the

interview; the other two nurses, psychologist 1, the two psychiatrists and the medical director for primary care were not.

13.9 Psychologist 1 told us later in writing that the director of mental health sent an email to psychologist 2 on 29 July 2009 stating that "*panels formally interview people, at which representatives or friends are allowed as support.*" Psychologist 1 told us: "*This contradicts the action taken by the director of operations and the fact that I was informed that it was not appropriate at that stage of the investigation for staff to be accompanied.*" We obtained a copy of the email from the director of mental health. The full wording of the section quoted by psychologist 1 said: "*Any stone unturned will be ... scrutinised by an external inquiry following the court case anyway. At such inquiries all documents are made available without question and panels formally interview people, at which representatives or friends are allowed as support.*"

13.10 We saw a copy of an email sent to one of the nurses who was interviewed on the same day as psychologist 1. This was the nurse who was accompanied to the interview. The email was dated 9 July 2009. It was headed "*SUI AM Interview – CONFIRMATION*". The email said: "*This email is to confirm that a meeting has been arranged for you as follows: - Monday 20 July 2009*". The time and venue were given but there was no other information in the email.

13.11 Psychologist 1 told us she found the interview intimidating and she felt angry and frightened afterwards. The director of operations told us the interview was clearly not pleasant for psychologist 1 and he tried to help her think about what she was saying. He said she would have been told she might be called to give evidence at Mr A's trial and to the independent investigation commissioned by the SHA. Psychologist 1 told us in writing that she did not feel that the director of operations helped her to think about what she was saying.

13.12 Notes of the interviews held on 20 July 2009 were sent by email at 10.45am on 23 July with a request for comments and amendments by the end of the following day. Psychologist 1 returned an amended copy of the notes of her interview within this deadline attached to a covering email dated 24 July. This amended copy and the email were included with the documents we saw as evidence of the timeline of actions following the incident. The CTP's report of the internal investigation was finalised between 11 and 27 August 2009. However, psychologist 1 told us the director of operations refused to

accept her amended notes of her interview and told her he had already written the report. Psychologist 1 gave us a copy of the amended notes that she said she had given to the director of operations but this copy included more amendments than the version we saw previously. We wondered if this was a second set of amendments prepared at a later date. Psychologist 1 told us in writing that she felt "*an equally valid explanation is that the notes were amended by some third party*".

13.13 The CTP's timeline indicated that consultants 1 and 2 were asked to return their amendments to the notes of their interviews within four days. We were told that this was because they were seen first and had longer before the deadline.

13.14 The director of operations told us that extracts of the CTP's report referring to individuals were sent to those individuals for comment. Psychologist 1 told us she could not remember much about this but she thought she was given extracts to read but was not allowed to keep a copy. We have seen the written comments she returned by email on 7 August, with an apology for a short delay over a weekend.

13.15 The director of operations told us psychologist 2 was not interviewed as part of the CTP's internal incident investigation because she never met Mr A. She was interviewed as part of a subsequent process but she told us she received nothing in writing and was not clear about the purpose of the interview.

13.16 Psychologist 1 told us she received a letter from the CTP dated 23 November 2009 asking her to attend a second interview. We explained we would be unable to consider processes outside our terms of reference and psychologist 1 told us she felt the two interviews were linked. She read the letter to us and it was clear the second interview was part of a separate process. Psychologist 1 told us that, based on previous communications, she was expecting to be interviewed for a second time as part of the CTP's internal incident investigation and therefore remained confused about the purpose of the second interview.

13.17 During the CTP's internal investigation, psychologist 2 raised concerns about psychology case notes being seen by a member of staff who was not a psychologist. We understand a number of psychology records were examined to check the standard of record keeping. Psychologist 2 felt this should not have been done without the service

user's written consent because of verbal assurances given by psychology staff about confidentiality, and because of the sensitivity of the content of the records.

13.18 The CTP's records management policy says in paragraph 18.3 that the CTP supports the idea of shared records in which all members of the healthcare team who are involved with a patient make an entry into a single record with an agreed local protocol in place. In paragraph 7.1 it refers to the NHS Care Records Guarantee which sets out fundamental principles for patients about how the NHS will use their information including *"Others may also need to use records about you to…manage the health service"*.

13.19 The British Psychological Society's (BPS) document Record Keeping: Guidance on Good Practice says in its introduction that a psychologist's records should be "*accessible and useable by clinicians and managers who have a 'need to know'."* It says on page 6 *"The prevailing view is that records belong to the employing organisation…they are contributed to by the professional working with the person."* It also says on page 7 that psychologists should *"ensure from the first contact that clients are aware of the limitations of confidentiality, with specific reference to: (a) potentially conflicting or supervening legal and ethical obligations; (b) the likelihood that consultation with colleagues may occur in order to enhance the effectiveness of service provision"*.

13.20 In a letter to psychologist 2 dated 29 December 2009 the SHA explained that any records about an NHS patient belong to the Secretary of State for Health and the CTP has a duty to ensure the records are of a sufficiently high quality.

13.21 The CTP's report of the internal investigation examined Mr A's care and treatment in some detail. It concluded the diagnostic process was impressive; the diagnosis was sound; the case did not warrant referral to neuropsychology but might have benefited from a full psychological assessment and psychometric testing. The report concluded an opinion from older people's psychiatry could have been sought, but that a second opinion was obtained because two other consultants assessed Mr A at his second and third section 136 assessments. The report also concluded the use of antipsychotic medication was clinically appropriate but that, given the increase of aripiprazole and the introduction of epilim, it would have been safer practice to continue with the admission or arrange community follow-up. The report did not discuss the possible effect of Mr A's second stroke.

13.22 The report concluded psychological support might have helped Mr A to explore and cope with his pseudohallucinations and to seek help with his drinking but community follow-up might have been more effective. It also concluded that practice around referring to and getting feedback from psychology was very poor; the quality of recording for Mr A was exceptionally poor but did not reflect usual practice; the psychology department was under considerable strain and the MDT were not proactive in seeking psychologist 1's opinion before discharge.

13.23 The report concluded alcohol was a significant factor in Mr A's mental health problems; there was no follow-up to see if he used The Junction or to monitor his drinking; risk assessment was not robust; CPA and discharge processes were poor; the use of different files and databases meant important information might be missed and it would have been prudent to introduce a care coordinator from the adult CMHT. The report concluded Mr A was offered outpatient appointments but did not link this to the letters being returned by the postal service. It concluded there was agreement that Mr A would continue treatment under the care of his GP but there was no evidence of this agreement.

13.24 The CTP's executive summary said Mr A was given a robust psychiatric assessment and risk assessment by psychiatrists and nurses but did not receive a thorough assessment from a psychologist. The full report did conclude the psychiatric assessment was thorough, and we have commented on this above, but it did not conclude that the risk assessment was thorough. The full report said the ward manager felt the risk assessment process was not robust and the report identified several risk factors that were not adequately considered.

13.25 The executive summary said that when Mr A could not be contacted his mental health file was closed, his GP was notified and he was discharged from mental health services in December 2008, but there was no evidence for any of these conclusions.

13.26 The final section of the CTP's report set out a sequence of root cause analysis techniques and included the use of the Incident Decision Tree[20].

13.27 The report of the CTP's internal investigation was submitted to the SHA on 27 August 2009. The executive summary of the CTP's report was revised in May 2010 as

[20] Created by the National Patient Safety Agency (NPSA)

version five but dated August 2009 in the footer. It was updated in February 2011 with references to the court case, still as version five, and still dated August 2009 in the footer.

Findings

13.28 The CTP's incident reporting policy has been in place since March 2007. It set out the actions required after a serious incident with limited information about the process of an investigation and a brief outline of the principles of root cause analysis. It did not include guidance on interviewing witnesses. We were not able to obtain a copy of the CTP's related document on the investigation of incidents.

13.29 The email of 29 July 2009 from the director of mental health to psychologist 2, about representatives or friends being allowed as support, was referring to the conduct of interviews for an external or independent investigation.

13.30 The CTP held an immediate management review of the incident, identified a multidisciplinary investigation team with external advisors and established a decision panel to oversee the investigation.

13.31 The investigation team created a chronology of the actions taken after the incident with documentary evidence.

13.32 The CTP interviewed key people except for psychologist 2, who had had no direct contact with Mr A.

13.33 The CTP interviewed the GP and practice nurses but did not ask them what they knew about Mr A's contact with mental health services.

13.34 Psychologist 1 did not receive written notification of her interview for the CTP's internal incident investigation, and said she remained unclear about the purpose of her second interview, which was part of a separate process.

13.35 Staff were not invited to bring a companion to their interviews but one of the nurses interviewed on the same day as psychologist 1 did bring a companion.

13.36 Nursing staff and psychologist 1 were given less than two days to return comments on the notes of their interview. Consultant psychiatrists 1 and 2 were given four days to return comments because they were interviewed earlier.

13.37 Psychologist 1 found her interview for the CTP's internal incident investigation intimidating. The director of operations said the interview was clearly not pleasant for her but he tried to help her think about her responses. Psychologist 1 did not feel he helped her to think about her responses.

13.38 Psychologist 1 felt the notes of her interview were incomplete and inaccurate. She returned amendments to the notes of her interview within the deadline but her recollection of the sequence of events differed from the evidence in the CTP's timeline. She gave us a different version of her amendments and suggested that the version held by the CTP had been tampered with.

13.39 Psychologist 1 was shown extracts of the CTP's report that related to her and returned written comments with an apology for a short delay over a weekend.

13.40 Psychologist 2 objected to the audit of a sample of psychology case notes as part of the CTP's internal investigation because of assurances given by psychology staff about confidentiality and because of the sensitivity of the content of the records. The audit was undertaken to check the general standard of record keeping.

13.41 Local, national and professional guidelines support shared clinical records with information for service users about limits on confidentiality. Records may need to be accessed to manage the service.

13.42 The CTP's report was detailed and identified many of the key issues but there were discrepancies between the executive summary and the full report. Some conclusions were not based on evidence.

13.43 The CTP's report concluded the second and third section 136 assessments constituted a second opinion.

13.44 Separate sections on root cause analysis and the incident decision tree were included in the report.

13.45 The correct date and version number of each update of the executive summary was not shown on the document.

Comment

13.46 ***We were impressed by the process followed by the CTP in holding an immediate management review, establishing a decision panel to oversee the internal investigation, drawing up terms of reference and identifying a multidisciplinary investigation team with external advisers. This was in line with Department of Health requirements and National Patient Safety Agency guidance on good practice in serious incident investigation. The investigation team had an appropriate balance of senior internal and external members for a small organisation and did not include anyone from Mr A's MDT. The timeline of actions following the incident was helpful to us in gathering evidence for the independent investigation.***

13.47 ***We recognise the constraints of the timescale for completing internal investigations into serious incidents, but we were concerned about the lack of a formal process for inviting staff to interviews. It is important that staff understand the purpose of the interview beforehand and there are clear boundaries between incident investigations and disciplinary processes. It is good practice to ensure debriefing, support and counselling is available; to facilitate discussion within the MDT about the incident wherever possible; to write to interviewees to explain the purpose and process of the investigation; to advise them they are welcome to bring a companion; to explain how the interview will be recorded and to set out a reasonable timescale for checking any record. Great anxiety usually follows a serious incident and such measures can help avoid making things worse.***

13.48 ***We were particularly concerned that psychologist 1 was not invited to bring a companion to her interview, given the concerns about her contact with AM. We saw no corroboration of her claim that she was told it was not appropriate for staff to be accompanied at that stage of the investigation. Indeed we saw no evidence of any policy about interviewing staff after serious incidents. As one of the nurses was accompanied to their interview, we feel it is more likely that staff were not proactively informed of this option.***

13.49 *We were surprised psychologist 2 was not interviewed as part of the internal incident investigation. She had not met Mr A but she was the manager and supervisor of psychologist 1 and had been head of department since 2005. It would have been appropriate to interview her about the processes in place for seeking a psychological opinion and this might have avoided some of the difficulties that arose subsequently in relation to this case.*

13.50 *We do not accept the suggestion that someone might have tampered with psychologist 1's amendments to the notes of her interview. We could see no benefit to anyone in doing this. The version held by the CTP was emailed by Psychologist 1 within the deadline. We do not know why she gave us a different version.*

13.51 *It was reasonable for the CTP to review a sample of psychology case notes as part of the internal investigation. We feel they had an obligation to do so. Service users should not be given an assurance of confidentiality that excludes this possibility or any other aspect of the organisation's responsibilities.*

13.52 *Despite our reservations about the CTP's findings on diagnosis and treatment, we found the report remarkably thorough, given the timescale. However, we feel the executive summary did not convey all the findings or the balance of the full report. For example, the executive summary said Mr A was given a robust psychiatric assessment and risk assessment by psychiatrists and nurses but did not receive a thorough assessment from a psychologist. The full report did conclude that the psychiatric assessment was thorough, and we have given our opinion on this in the sections above, but it did not conclude that the risk assessment was thorough. The full report said the ward manager felt the risk assessment process was not robust at the time and the report identified several risk factors that were not adequately considered.*

13.53 *It was not valid for the CTP to conclude there was an agreement that Mr A would be monitored by his GP, or that his mental health file was closed, or that his GP was notified or that he was discharged from mental health services in December 2008. We saw no evidence for any of these conclusions.*

13.54 *We do not agree that the second and third section 136 assessments constituted a second opinion as they did not appear to be based on full access to the*

clinical records and could only have considered the situation at the time. They were not documented by the consultant psychiatrist and the third assessment was not communicated to consultant psychiatrist 1. A second opinion should consider the case over time and take into account all the variables necessary to formulate an opinion.

13.55 *Root cause analysis provides a structure to underpin the investigation if it is chosen as an investigation technique, as suggested by the Department of Health. It should be apparent from the identification and analysis of problems in the main body of the report that root cause analysis has been used, without the need for a separate description. Despite the diligence shown in setting out the findings in terms of root cause analysis as well as in the main body of the report, it appears to have resulted in less clarity, with findings and conclusions about each topic shown in various sections of the report.*

13.56 *The incident decision tree created by the National Patient Safety Agency is intended for use by managers considering the actions of individual members of staff. It makes use of findings of root cause analysis and is complementary to it but is not part of the basic technique.*

13.57 *We agree with the CTP's overall conclusion that there were no clear root causes for this incident. It was reasonable for the CTP to conclude that Mr A's heavy drinking might have been a significant factor, although the updated executive summary said the findings of the court did not support this.*

13.58 *It was reasonable for the CTP to update the executive summary before it was released but the correct date should have appeared on each document and the correct version number on each draft.*

Recommendations

R15 NAViGO should ensure current policy on the investigation of serious incidents reflects good practice, such as the guidance from the National Patient Safety Agency, particularly for supporting and interviewing staff and including: debriefing; support and counselling; facilitated discussion within the MDT; written information about the purpose and process of the investigation; interview techniques; being accompanied at interview

and confirmation of the record of the interview. The policy should include a robust system of dating and version control for serious incident investigation reports and executive summaries. [see paragraphs 13.47, 13.48, 13.58]

R16 NAViGO should ensure all information given to service users by each department about confidentiality and data protection complies with national and local policy and does not conflict with NAViGO's clinical and managerial responsibilities. [see paragraphs 13.17, 13.51]

The strength of the recommendations in the internal report

Findings

13.59 The CTP's report listed recommendations and actions. These covered securing information following an incident; CPA and risk management; reduction of separate files and databases; psychology recording; psychology service; discharge, follow-up and transition and medication in primary care.

Comment

13.60 ***The CTP's recommendations were based appropriately on the key findings of the internal report. They were broad rather than specific but details were included in the action plan.***

The quality, implementation and review of the action plan

Evidence

13.61 The initial action plan indentified specific actions, the person responsible for each action and the progress made by 31 July 2009. Further actions were included with a timescale for each one.

13.62 Progress on the action plan was monitored at the monthly clinical governance meetings and formally reviewed in April 2010 and in August 2011. Details of the evidence of implementation were added at each review. All actions have been identified as 'green' (completed) except for the review of New Ways of Working[21], which is identified as 'amber' (in the process of being completed).

13.63 We did not ask to see all the evidence referred to in the CTP's review of the action plan except for two representative policies.

13.64 The director of operations told us some of the improvements were well understood and already in process and others were brought into focus by the internal investigation and the resulting action plan. He told us that the action plan has been implemented, regularly reviewed and audited.

13.65 He also told us much has been achieved in developing New Ways of Working, but this is ongoing and requires stronger working relationships with GPs to decide which cases are held by NAViGO.

Findings

13.66 The initial action plan was specific and was expanded and enhanced later.

13.67 Progress on the action plan was monitored at the monthly clinical governance meetings and reviewed in April 2010 and August 2011.

13.68 Evidence of the implementation plan was included at each review.

Comment

13.69 ***The expansion and enhancement of the initial action plan was appropriate. It is rarely possible to prepare a robust action plan at the same time as the recommendations. This needs time and consultation to ensure it is realistic and measurable and the CTP clearly applied these principles.***

[21] Department of Health guidance on the delivery of mental health services issued October 2007

13.70 ***Clear and specific evidence of completion was identified on the action plan. The nature of the evidence, such as reference to audit reports, minutes of meetings, establishment of training initiatives, ratification of policies and the appointment of new staff, indicated a robust implementation process. We did not need to see all the evidence apart from two representative policies. We were satisfied the CTP and NAViGO have been diligent in implementing the action plan and have good evidence to support this.***

Recommendation

R17 The CTP should obtain evidence that all actions resulting from the internal investigation have been completed.

Overall conclusions on the CTP's internal investigation

13.71 The CTP's overall approach to the internal investigation impressed us but we were concerned about aspects of the interviews. Good practice was not followed in inviting staff for interview, nor in inviting them to be accompanied, nor in providing information about the overall process. This probably contributed to some of the subsequent difficulties.

13.72 We did not agree with the CTP's conclusions on diagnosis and treatment, but we found the internal investigation report remarkably thorough despite some inconsistencies between the executive summary, the full report and the evidence.

13.73 The CTP's recommendations were soundly based on the findings of the investigation. The action plan was robust and measurable with clear evidence of implementation.

14. Overall conclusions of independent investigation

14.1 We saw and heard a great deal of helpful evidence during our investigation. Some of the evidence we received was contradictory, some of it did not fall within our terms of reference and some of our questions could not be answered. We aimed to reach proportionate, appropriate, fair and reasonable conclusions based on the balance of probabilities.

14.2 We concluded that Mr A's assessment by the mental health service was incomplete, his diagnosis was unclear and staff did not really get to know him. He was not followed up assertively when he left hospital but staff did not know where he was living. We identified problems within the organisational processes but we found no causal link between these problems and the tragedy of 2009. Many substantial improvements have since been introduced.

14.3 The CTP's internal investigation process was based on recognised good practice but there were some problems with staff interviews. We did not agree with the CTP's conclusions on diagnosis and treatment but otherwise found the report remarkably thorough. It was followed through with a robust, evidenced action plan.

14.4 We are grateful for the contributions and support of all the people we interviewed, those who provided documentary evidence, those who facilitated our investigation and those who commented on our draft report.

15. Recommendations

R1 NAViGO should encourage senior clinicians to contact specialists by telephone about the management of actual or suspected physical comorbidity [eg organic brain disease], especially where there are abnormal findings, and to document these discussions. [see paragraphs 5.87, 5.88, 8.147]

R2 NAViGO should encourage senior clinicians to reflect on diagnostic uncertainty and discuss complex cases with peers on an informal basis in addition to discussions within the clinical team. Discussions must be documented in clinical records and in minutes of team meetings. [see paragraphs 5.93, 8.151]

R3 NAViGO should ensure consultant psychiatrists either make or countersign a single entry in the clinical records that clarifies the formulation and opinion of the team after pulling together the opinions of different disciplines. This entry should include the rationale for treatment decisions especially when such decisions are controversial or not supported by clinical evidence or are off license. NAViGO should audit this standard. [see paragraphs 5.71, 5.73, 5.81, 5.89]

R4 NAViGO should ensure current operational guidance emphasises the potential benefit of contacting close associates of the service user, even if he has no formally identified carer. [see paragraph 5.86]

R5 NAViGO should ensure psychologists' case loads and job plans are appropriate and reviewed on a regular basis. [see paragraphs 8.31, 8.106]

R6 NAViGO should ensure there is a robust system of supervision for clinical staff which does not rely on the supervisee raising their own concerns about individual cases. Supervisors should identify some cases for discussion and ensure that all cases are discussed within an agreed timescale. [see paragraphs 8.70, 8.104]

R7 The CTP should ensure drug and alcohol services are commissioned to provide an appropriate and accessible service for mental health service users, including inpatients, with a clear mechanism to resolve problems between the services. [see paragraphs 8.119, 8.126]

R8 NAViGO should finalise a policy for accessing drug and alcohol services, to ensure there are clear criteria for accepting mental health service users, including inpatients, and to establish a clear route to discuss problems between the services. [see paragraphs 8.119, 8.126]

R9 NAViGO should ensure there are robust systems for adults of working age teams to seek an opinion from the older people's service and for recording the outcome. [see paragraph 8.148]

R10 NAViGO should ensure there are robust links between the inpatient consultants, the home treatment team and the outpatient consultants that allow for consultation and effective handover. [see paragraph 9.29]

R11 NAViGO should audit the accessibility, content and timeliness of the summary of significant information about a service user, including 136 assessments, available on MARACIS, to ensure it is available in an emergency and includes appropriate information. [see paragraphs 10.17, 10.19]

R12 NAViGO should audit the mechanism for telling consultant psychiatrists and GPs that one of their service users has had a section 136 assessment that did not result in admission, to ensure it is prompt and robust. [see paragraphs 10.18, 10.19]

R13 NAViGO should ensure documented clinical supervision of junior doctors takes place and that case based discussion and scrutiny by the consultant of medical records and written communications completed by junior doctors are key tools in workplace based assessment. [see paragraph 11.16]

R14 NAViGO should liaise with the local police service to ensure the process for confirming any informal joint agreements on managing people known to both services is robust. These agreements should be flagged up by information systems when any significant event occurs. This is for people not involved with the forensic service or with any other formal joint process. [see paragraph 11.20]

R15 NAViGO should ensure current policy on the investigation of serious incidents reflects good practice, such as the guidance from the National Patient Safety Agency, particularly for supporting and interviewing staff and including: debriefing; support and

counselling; facilitated discussion within the MDT; written information about the purpose and process of the investigation; interview techniques; being accompanied at interview and confirmation of the record of the interview. The policy should include a robust system of dating and version control for serious incident investigation reports and executive summaries. [see paragraphs 13.47, 13.48, 13.58]

R16 NAViGO should ensure all information given to service users by each department about confidentiality and data protection complies with national and local policy and does not conflict with NAViGO's clinical and managerial responsibilities. [see paragraphs 13.17, 13.51]

R17 The CTP should obtain evidence that all actions resulting from the internal investigation have been completed.

Appendix A

Chronology of care and treatment

Previous history

23 November 1955 – Mr A born in Northern Ireland.

1975 – Married. Mr A had two children.

1994 – Moved to North East Lincolnshire for work.

10 August 1994 – GP recorded Mr A drinking 80 units of alcohol a week.

1996 – Divorced.

26 April 1999 – Note on GP new patient questionnaire: drinking 40 units of alcohol a week.

23 January 2004 – Mr A attended A&E at Diana Princess of Wales Hospital (DPOW) Grimsby with "*numbness in arm*". Diagnosed with a strain or sprain in the left shoulder.

27 January 2004 – Seen by GP with pain in left shoulder and lost sensation in tips of two fingers on right hand.

9 May 2004 – Mr A attended A&E at DPOW Hospital feeling unwell. Diagnosed with early Wernicke's encephalopathy[22] and discharged. Re-attended A&E later the same day. Found to have left sided weakness, facial droop and slurred speech.

10 May 2004 – Admitted to hospital with non-haemorrhagic ischaemic infarct[23] in right parietal lobe of brain.

17 May 2004 – Mr A was discharged from hospital.

[22] An inflammatory brain disease caused by thiamine deficiency that affects people with long term excessive alcohol use.
[23] Area of damaged tissue resulting from obstruction of local circulation

18 May 2004 – GP recorded: Had L CVA (stroke) affecting speech and left arm on 9 May 2004 and was drinking 2-4 pints on alternate days.

30 July 2004 – Mr A was reviewed at DPOW Hospital following stroke on 9 May. Letter to GP: Doing well with no weakness in limbs; "*echocardiogram showed no intra cardiac thrombus, LV systolic function is satisfactory and all the valves appeared normal*". Discharged for GP to check cholesterol and continue aspirin and statins.

9 December 2004 – Attended A&E at DPOW Hospital with "*swelling to foot*". Diagnosed with gout and discharged.

July/August 2005 – Mr A was seen weekly by alcohol counsellor working for GP and at The Junction[24]. Alcohol reduced from 60+ to 16 units a week.

2 January 2007 – Mr A attended A&E from work with severe headache, admitted to Medical Assessment Unit at DPOW Hospital and discharged next day. Discharge letter noted:

> "*Frontal headache, sudden in onset, pain intensity 10/10, lasted for an hour, the patient did not feel steady and fell to the ground for a couple of minutes. He did not lose consciousness but developed double vision for a couple of hours afterwards. He had tightness around the lower side of his chest on the right side; he had never had such a severe headache before. No fits and no urinary incontinence… CT head: old infarction, no recent infarct, no mass effect, no midline shift…The patient was diagnosed with a severe headache…No further follow up was arranged.*"

June 2008 to June 2009

2 June 2008 – Mr A was detained at a police station under Section 136 of Mental Health Act 1983 (MHA) and assessed by consultant psychiatrist 1, another doctor and AMHP1. He had brought himself to the police station saying he was having ideas of self-harm and voices telling him to kill other people. He had a knife with him.

[24] Drug and Alcohol service provided by Rotherham, Doncaster and South Humber NHS Foundation Trust

2/3 June 2008 – Mr A was admitted informally[25] to a mental health ward at DPOW Hospital Grimsby. AMHP1 recorded on Emergency Duty Team (EDT) report: Mr A said he had been hearing voices for past 4 weeks. "*This afternoon he had drunk 3 pints of beer…episode in hospital in 2004 related to his having had 2 mini strokes*". AMHP1 also recorded: only significant event in last 4 weeks was death of sister-in-law when he was a pall bearer. Voices worse over past two days. Police said he had not had a drink. Mr A had gone out after voices told him he is better than everyone else and to kill them. Mr A said he had poor diet and poor sleep pattern. Unemployed so had little money for drink. Last had drink three days ago. Mr A said he needed help as he believed he would harm someone. Information obtained from out-of-hours GP service that he was alcoholic, drinking up to 86 pints per week and had a rash that may be scabies.

2 June 2008 – Brief-DICE risk assessment: risk of harming others; risk of symptoms of alcohol withdrawal; options: nurse in safe environment; 1:1 support if wants to talk and vent feelings about voices; compliant with medication; observe for alcohol withdrawal.

3 June 2008 – Ward staff recorded: Mr A unable to remember address whilst at police station but ward staff found it via GP. GP also confirmed that rash was scabies. Mr A said he had a problem with drinking in past but not at present. Staff noted tremor and sweating. He talked about voices in his head telling him to get a knife and kill people but he felt he could cope with voices and would approach staff otherwise. Appeared low in mood and tearful. Said voices cause him distress. Also recorded on admission form by SHO1: "*Denies drinking heavily recently, just 7 pints a week & denying any withdrawal symptoms & is not eye opener, poor sleep and appetite…describing hallucinatory auditory experience of pseudo hallucinatory nature 'inside my head'…no thoughts of harming others*". Care plan - goal: Mr A to use coping strategies when hearing voices; to be compliant with all treatment; to approach staff if voices troubling him. Nursing action: to offer time and ask how to help him; to discuss coping strategies for hearing voices. Signed by Mr A. Referral form included permission to contact his mother and gave her telephone number. Quetiapine was prescribed.

4 June 2008 – Mr A spent time watching television and smoking outside. He joined in a game of rounders and appeared to enjoy this. "*No management problems*". Blood results indicated he had alcohol problem and was actively drinking.

[25] An informal admission is without use of the Mental Health Act

5 June 2008 – Ward staff recorded he engaged well, was pleasant with no evidence of responding to voices. At clinical review with consultant psychiatrist 1, staff grade doctor noted: appeared settled with no psychotic symptoms observed. Felt emotional because staff treated him well and not used to that. Claimed still to hear a voice in his head saying again and again "*You are better than them, kill them!"* The voice was continuous. Some memory problems – sometimes cannot remember where he lives. Lives on his own – all family in Newcastle. Denied suicidal thoughts. Appetite improved since admission. "*In fact he was so terrified that he would kill someone with the knife he was carrying, that he presented himself to the police station to ask for help"*. Plan: MRI scan; referral to Old Age Psychiatry; MMSE [mini mental state examination]; continue quetiapine; check vitamin B1 & B12 & folate; BP monitoring twice a day. Also noted on clinical review form: "*shaking in hands evident ? alcohol"* . Later ward staff recorded that when they spoke to Mr A about his new drug quetiapine, they discovered he had had two minor strokes. Staff sought advice, confirmed that amisulpride had little association with strokes/thrombosis and informed staff grade doctor who would consult consultant psychiatrist 1. East Sector access meeting minutes noted Mr A was admitted for investigation.

6 June 2008 – Mr A said he was troubled by voice in his head. Given haloperidol which gave some relief.

7 June 2008 – Ward staff noted he was pleasant, no symptoms of psychotic illness, no evidence of responding to hallucinations, other than self-reporting. Mr A referred to memory loss at time of admission but showed no difficulties today.

8 June 2008 – Ward staff noted he scored 27/30 in mini-mental state examination. He insisted that when he was admitted he could not remember his name or address but could always remember information on football.

> *"He attributed mild memory problems to his stroke some years ago. Mr A described his voice as one male with a Geordie accent constantly telling him to kill others. He stated this was occurring during our chat. There were no observed difficulties concentrating or evidence of responding. In discussing life in general he talked of the recent stress of carrying the coffin at his sister-in-law's funeral. We talked about bereavement counselling as a possibility. Is currently on jobseeker's allowance and is keen to get into employment though struggles with*

application forms due to his left sided weakness and difficulties writing. We briefly discussed the possibilities of support [with employment].*"*

9 June 2008 – Ward staff spent time with Mr A to complete demographic information. He answered all questions apart from his mother's address. He lived in a shared house with four men and said *"no problems with this"*. He was clear about his care plan. He said voices were there but manageable. He only wanted his mother contacted in emergency "*unless he was admitted to somewhere high security. He began talking about units such as Rampton and that he hoped he could 'sort myself out there'."* He also spoke about forklift driving and said he would be glad to speak to an employment advisor.

9 June 2008 – Letter from SHO2 to older people's CMHT: Mr A hearing voices for past three weeks – male voice telling him "*I better go and kill him or her*". No suicidal ideas or thoughts of harming others and good insight. Liver function test showed:

> "*…deranged liver enzymes, gamma GT elevated to the level of 490. Mr A had right middle cerebellar tree infarct in 2004 with no residual left sided weakness. CT scan of 10 May 2004 revealed a non-haemorrhagic ischaemic infarct in the right parietal lobe involving the cortex and subcortical white matter. He had a repeat scan in 2007 which revealed no new pathology."*

Letter said Mr A was scheduled for MRI scan and requested older people's CMHT to review him and possibly take over management. A handwritten note dated 13 June by senior nurse on copy of this letter in older people's file stated: "*Spoke to* [SHO2] *referral made too soon, not stable on ward, looking at alcohol problems"*.

9/10/11 June 2008 – Ward staff noted: pleasant, settled and appropriate.

11 June 2008 – At clinical review with consultant psychiatrist 1, SHO2 recorded that Mr A said he was doing fine. "*The voices are very low now - diminishing though he still hears them but he's not going to act on them"*. He admitted to a problem with alcohol about two years ago but said he does not drink more than seven pints per week now. He wishes to go back to work. Plan: increase quetiapine; advised to stop alcohol; repeat blood; for possibility of leave. Staff recorded that referred for MRI; if all results fine, to start day leave then refer to the Junction with a view to discharge. Also noted on clinical review form: '*alcohol issues were addressed*'. In the afternoon Mr A went to the opticians. On

return he said he had a panic attack. He said he had managed it but felt it was because it was his first excursion off the ward. "*It was a bit of a shock to him/felt overwhelmed*".

12 June 2008 – Ward staff noted he was pleasant, with no evidence of auditory hallucinations. Mr A had an MRI scan. MRI report the same day said: "*An old left posterior frontal infarct demonstrated. No evidence of new infarction. There is no SOL* [space occupying lesion]". Report signed by consultant psychiatrist 1. East sector access meeting minutes noted Mr A to be referred to the Junction.

13 June 2008 – Ward staff noted: bright in mood, appropriate in manner. He asked to go out in afternoon to prove to himself he would be alright. Planned to walk around town among people to see how he felt and then walk around market to be among more people in a crowd. Staff nurse asked him "*not to push himself too hard and to know his limitations*". When he returned staff suspected he had had some alcohol but he denied this and was settled and pleasant.

14/15 June 2008 – Ward staff noted: settled and pleasant, mixing well with staff and patients. Mr A left the ward both days and returned without concern. His blood pressure was within normal range, although he said he sometimes felt dizzy with a dry mouth. He was advised to inform staff when it happened again.

16 June 2008 - At clinical review with consultant psychiatrist 1, SHO2 recorded: said leave was fine but had about six pints of beer; said medication had reduced auditory hallucinations, but he was still hearing voices. "*MRI - no new findings*". Plan: update risk assessment; discharge home today; for follow up by ward; stop alcohol and visit the Junction; continue medication; contact ward/crisis team if needed; contact Elderly for outpatient follow up. Staff also noted: "*Mr A will be given seven days medication. The doctor requested a full elderly assessment in the community. Mr A is pleased to be going home*."

16 June 2008 – Discharged on standard CPA. CPA documentation not signed. New key worker and care co-ordinator: consultant psychiatrist 2 (community consultant); to attend ward two days later on 18 June for seven-day follow up. Risk assessment evaluation said:

> "Mr A *has appeared settled…no visible evidence of him responding to voices and he has not approached nursing staff with any concerns with regards to him and*

voices. Mr A has shown no indications or made any attempts to harm anybody whilst on the ward. Mr A does not appear to be suffering any of the withdrawal symptoms of alcohol. It appears the risk of Mr A harming others when hearing voices has reduced and the risk of symptoms of a withdrawal from alcohol has reduced."

Notification of discharge form (completed by SHO2 and signed by consultant psychiatrist 1) included: '*Diagnosis: mental and behavioural disorder due to use of alcohol ICD10 Code: F10.5…Community care plan: to be supported by ward staff then CHTT* [crisis home treatment team]; *to continue medication; to visit the Junction; to see the community consultant (elderly team) on 29/06/08'*. See entry for 20 June for full discharge letter.

18 June 2008 – Mr A attended ward for seven day follow up. Assessed by [nurse?]:

"Mr A informed us that he had been hearing voices which were telling him to harm others. He stated that 'although he had so far managed to resist the urge to carry a knife with him when leaving the house that he felt he would begin to in the near future due to the voices being overwhelming'. I asked Mr A to elaborate in regard to the voices which he said kept telling him that he was inferior to others and that because of that he needed to harm others before they harmed him. I further informed Mr A that carrying an offensive weapon was illegal. Mr A claimed he has been taking his medication as prescribed since his discharge but feels mentally unwell. Due to the claims that Mr A made I contacted the on call SHO so that he could be further assessed. The SHO contacted crisis team who assessed with them and decided that Mr A did not need to be readmitted. Before leaving I gave Mr A the Lincs Line number so he could access support. I also gave Mr A the number of the crisis home treatment team should he deteriorate any further."

18 June 2008 – Reviewed by the staff grade doctor and SHO2 who recorded:

"*Mr A said is still hearing voices in the head telling him to kill other people. Said this voice says 'You are better than them, harm them'. Lives in a shared accommodation and the voices are not telling him to harm them but others. Cannot recognise this voice but he's male so says he is frightened that he might harm someone. Said this is the first time of hearing voices. Says he has a short term memory problem, had to write down his medication in order not to forget.*

No financial problems. Said he started hearing these voices when his sister-in-law died. Worked last year. On jobseeker's allowance."

Plan: stop drinking alcohol; contact crisis team – number given – or come to A&E if voices get worse; to be seen soon by community consultant.

18 June 2008 – Letter to Mr A offering outpatient appointment with consultant psychiatrist 2 on 12 August.

19 June 2008 – Mr A was detained at a police station under Section 136 of MHA. He had walked into police station carrying knife and said voices were telling him to kill someone. Police took him to mental health ward where he was assessed at 10.45pm by consultant psychiatrist 3, another doctor and AMHP2. Admitted informally. AMHP2 recorded:

"Checked SWIFT[26] *- known but not an open case…Given information that Mr A was discharged from* [ward] *on Monday (16th) after being admitted in almost identical circumstances, ie hearing voices, carrying a knife and walking into Police Station. Staff feel this may not be genuine as Mr A was on the ward for several days and exhibited no signs of mental illness whilst there. Mr A spoke rationally. He said he is still hearing voices telling him to kill someone - no-one in particular and that he is petrified that he will end up doing what the voices are telling him to do. Seemed somewhat confused as to when he began to hear the voices…Said he tries not to believe or take notice of the voices, but it was difficult to ignore them because they are so loud.* [Consultant psychiatrist 3] *asked if he drinks alcohol (history of alcohol abuse) and he denied it - said he had a shandy at lunchtime whilst eating with a friend.* [Consultant psychiatrist 3] *warned him he should not take any alcohol whilst on his medication…Mr A's eagerness to remain in the hospital confirmed what we had all been feeling - that he was keen to be re-admitted. Not showing any significant signs of mental illness apart from claim to hear voices and threats to hurt someone…offered informal admission, which he quickly accepted, on the grounds that the safety of the public might be jeopardised if he was sent home and the risk could not be taken. Ward staff were expecting admission but realistically saying Mr A was likely to be discharged fairly quickly."*

[26] Local authority database

19 June 2008 - Brief-DICE risk assessment: risk of harm to others due to carrying knife; reports hearing voices; options: admit for further assessment. Care plan: goal: assess mental state further; identify risks & discharge to community with package of care; client action: adhere to ward boundaries; accept medication and report effects; seek support when hearing voices or distressed; participate in therapeutic activities on ward; nursing action: monitor effects of medication; offer 1:1 time to ventilate thoughts and fears; engage in therapeutic activities; liaise with other agencies.

19/20 June (overnight) - Admission form by SHO3 included: "*Scared about the voices. Feels safe in the ward…casually dressed, good eye contact, good rapport, unkempt, cooperative, smelling alcohol…insight good…stroke 2004…alcohol – shandy 3/week. No illicit drugs. Drank a shandy today.*"

20 June 2008 – Ward staff recorded:

> "*During admission Mr A was noted to have alcohol on his breath and he stated he had only drunk a shandy at lunchtime with his meal* [previous day] *though it smelled stronger than a small shandy. He was articulate during admission, showed full insight, no evidence of any hallucinations, auditory or otherwise. Mr A said he was frightened by this male voice and yet showed no signs of this profound fear he expressed. He was laughing and joking all through his admission and physical examination. He was able to say what medication he was on. He reported taking his medication appropriately since discharge o 16/06/08. Mr A went to sleep immediately after his physical examination and appears to have slept well."*

Later that day reviewed by consultant psychiatrist 1 and staff grade doctor who recorded:

> *"Still hearing continuous voice saying 'You are better than him. Kill him (or her)'. This is a voice and not a thought and seems to come from the right side of his head. Denies any illicit drug misuse. Plan: assessment of mental state; EEG referral on Monday; continue quetiapine 250mg bd till Sunday when it should be increased to 300 mg bd."*

Ward staff also recorded: "*no evidence of responding or thought disorder*"; pleasant, talking with staff and patients.

20 June 2008 - Discharge letter (for discharge of 16 June) from SHO2 to GP included: Diagnosis: mental and behavioural disorder due to use of alcohol; ICD10 Code : F10.5; Medication on discharge: aspirin; simvastatin; enalapril; quetiapine; betnovate cream; Progress on ward: commenced on medication; quetiapine titrated up to 250mg bd, considering background of stroke in 2004. Admitted significant reduction in auditory hallucinations and feeling much better but not totally disappeared.

> *"He had a repeat MRI scan which showed an old left posterior frontal infarct. No evidence of new infarction. There is no space occupying lesion. Mr A admitted to drinking excessively in the past but said he had cut down recently and was willing to stop drinking alcohol. His liver function test revealed elevated gamma GT and deranged liver function test…closely observed by the ward staff and there was no evidence of responding to any form of voices. He was quite calm on the ward and* [participated] *actively in the ward activities. He ate and slept well and there was no cause for concern."*

Discharge plan: continue current medication; visit the Junction; outpatient appointment with consultant psychiatrist 2 in two to three weeks' time [but booked for 12 August]; contact CHTT if needed; seven day follow up by ward.

21 June 2008 – Ward staff recorded he remained pleasant and appropriate with no evidence of voices or psychotic features. During the morning he said he felt unwell. Staff checked vital signs and consulted the on-call doctor. After resting on his bed Mr A got up and said he felt better. In the evening he appeared stable and went out with "*his visitor*".

23 June 2008 – Referral for EEG by SHO2:

> "*52 year old presented with hearing voices in his head saying 'you are better than him/her kill him'. This voice is coming from the right side of the head. Had* ['old' struck through] *left posterior frontal infarct (stroke) in 2004. Repeat MRI reveals no new abnormality (06/08). However, no psychotic features while in ward… ? Organic Psychosis,* [?] *alcohol induced.*"

25 June 2008 - At clinical review with staff grade doctor, SHO2 recorded:

> *"…doing fine on the ward. No evidence of responding to voices, not in any form of distress…said the voices are very low now and the medications are helping him but feels very drowsy and complains of sores on the heel of the foot – no discharge or fever. Plan: reduce quetiapine 300mg nocte; quetiapine 100mg od; monitor BP 8 hourly; referred to tissue viability specialist; for EEG on Friday. Plan: add aripiprazole 100mg od."*

25 June 2008 – DICES risk assessment: no longer talking of harming others; feels medication is helping with voices; possible side effects of medication; options: monitor daily for effects/side effects of medication.

26 June 2008 – Risk assessment evaluation: no longer feels will harm others; feels some side effects of medication "*drunk and drowsy*". Care plan evaluation: remains valid. East sector access meeting minutes stated: readmitted after presenting to police with knife saying hearing voice telling him to stab someone, noted to have alcohol on breath.

27 June 2008 – Had EEG. Ward staff recorded: "*ready and looking forward to discharge*".

28 June 2008 – Ward staff noted: slept well; pleasant and interacted well. Had time away from ward and returned around 5pm in cheerful and pleasant mood.

29 June 2008 - Ward staff noted: bright and light hearted; went out for afternoon to see a friend. Returned in appropriate mood.

30 June 2008 – Ward staff recorded:

> "W*hen awake in morning, Mr A claimed he never slept all night and was laid awake with eyes shut, struggling to sleep due to hearing voices. It was explained to Mr A when he is awake throughout the night, he must give a signal to staff to show this so it can be documented."*

Later staff noted: pleasant; joined in quiz; went out for hair cut; ate well and raised no concerns about hearing voices. In evening went out with staff and patients and said he really enjoyed the time off the ward.

1 July 2008 - Ward staff recorded: slept well and woke at 5:15am but said did not sleep well and was totally exhausted. Later staff noted: pleasant & took part in ward activities. EEG report said:

> "*EEG shows several episodes of mixed slow and sharp components. These are usually bilateral but sometimes with right-sided emphasis or occasionally appearing solely on the right. These features are most likely due to the antipsychotic medication suggesting lower seizure threshold.*"

On the same day progress notes said: doing well; compliant with medication; not observed responding to external stimuli nor reported any voices disturbing him but reported in review that still experiencing voices telling him to "*kill her*" or "*kill him*". Care plan goal: minimise side effects of medication. Actions about monitoring effects of medication.

2 July 2008 - At clinical review with consultant psychiatrist 1, SHO 2 recorded:

> "*Mr A was assessed by* [psychologist 1] *and no psychological features* [?] *noted. Ward staff noted that he coped better on quetiapine than on aripiprazole. He said the voice tends to be more on the right side of the head 'You are better than them kill them'. Complains of drowsiness from morning quetiapine. EEG reveals abnormality on right side. Mood is okay but frightened about the voice and worried about going out for hours* [or leave?]*, does not know what will happen. Willing to take medication. Plan: commence on mood stabiliser – epilim chrono 500mg nocte.*"

Ward staff noted before review there was no evidence Mr A was responding to auditory hallucinations or troubled by intrusive thoughts. After review staff noted Mr A said he was "*hoping to be discharged, but was happy to stay as long as the doctor felt it was necessary*". Also noted on clinical review form: "*Mood feels better but frightened by his voices. He stated new medication seems not working; voices keep him awake at night.*" Also noted by ward staff that risk assessment remained valid.

Psychologist 1's notes undated, wrong name and difficult to read, transcript available: voices in head told him to kill someone; voices not under control; no sleep Sun/Mon; frightened of what he can do; drank 2-9 each day, not a problem; work talked him into getting help, went to GP; unemployed for two months; memory: older stuff good, new

things difficult; dangerous voices; would like to say no but doesn't know if voices took over; keeps voices out if attention is focussed; can come back but not sure when leaves.

3 July 2008 – Ward staff recorded: "*Mr A was taken to look around the MIND group in Noble House Grimsby today. Mr A didn't appear very interested in the groups but did say he would like to go again…Mr A appeared in good spirits and a pleasant mood*". East sector access meeting minutes noted his mood better.

4 July 2008 – Discussion between staff grade doctor, ward sister, nurse from crisis team and police constable about Mr A's presentation to police on two occasions with a knife. The staff grade doctor recorded:

> "*Mr A's diagnosis not yet clear but EEG showed some changes (spikes) in R temporal area. Mr A just started on anticonvulsant medication. Despite his symptoms Mr A has full capacity to decide between right and wrong and he is fully aware that possessing a knife on the street is a criminal offence. He has been advised to contact A&E or CHTT if distressed. Accessing the Police instead of the mental health services is not to be encouraged. He will again be strongly advised to contact mental health services at times of distress. If he chooses to contact the Police while being in possession of a knife then he should be charged*[27] *accordingly. Plan: the above decision should be conveyed to Mr A; Mr A should be reassured that he will receive support from mental health services when necessary; Forensic Team to be informed so that they are aware of his presentation if they will be requested to assess him in the future.*"

Ward staff also noted: pleasant during outing with staff; no evidence of low mood or unusual behaviour.

5 July 2008 - Slept well and socialised well with no evidence of psychosis. Spent time away from ward and returned at 4pm as agreed in a stable mood.

[27] References to Mr A being 'charged' were changed in the CTP's internal investigation report to 'arrested' to reflect the legal process.

6 July 2008 - Slept well; was stable; very pleasant; ate well; showed no evidence of auditory or visual hallucinations.

> "*However he complained of pain around his calf and he is yet to be seen by the on call duty SHO. Positive reassurance was offered and later stated he can manage with it. He also utilised hospital grounds leave well.*"

Left ward between 2pm and 4pm and noted to be in good mood on return. Care plan evaluation: mental state improved; not made any comment about knife; going out appropriately; sleep improved; no evidence of hearing voices; negative effects of medication seem reduced.

7 July 2008 – Ward staff recorded: woke at 4.45am, went outside to smoke and on return reported shooting pains in left arm. Vital signs taken and escorted to A&E. In A&E given salbutamol inhaler and painkillers; X-rays and ECG done and nebuliser used for wheezy chest. Advised to see GP about chest in a few days. Returned to ward before 7am and later joined in ward exercise programme, appearing to really enjoy himself and had no trouble with the workout. At clinical review with consultant psychiatrist 1, SHO2 recorded:

> "*Informed of the decision of the MDT meeting that he has got capacity and would be charged for it. Said the voices are now less and medication is helping. No suicidal thoughts. Plan: leave till Wednesday; to contact ward/A&E if need be; continue medication.*"

Staff informed forensic team about discussion with police. Staff recorded:

> *"Spent one to one time with Mr A, he was very pleasant on approach, he was happy to be going on leave for a few days. He left the ward at about 17.00."*

7 July 2008 ? (undated) – Forensic assessment form initiated but not completed by forensic practitioner following telephone call from ward. Recorded on form: meeting held with police; decided Mr A had capacity to be responsible for actions and should be processed through criminal justice system if comes into contact with police again rather than being brought in on Section 136. "*Information shared with the team in case we see him in the custody suite*". Similar information recorded by consultant psychiatrist 2 in undated note.

8 July 2008 – On leave. No contact with ward.

9 July 2008 - At clinical review with consultant psychiatrist 1, SHO2 recorded:

> *"Mr A said leave went well, no problem at all, though still hears voices but they are under control with the medication. No alcohol during leave though was at the pub. Prepared his meals and had no problem with carrying knife…Auditory hallucinations* [?]. *No suicidal ideas or harm to others. Willing to continue medication. Has plans to go back to job on Monday. Plan: discharge home; for a 7 day follow up; fax to GP today in London; to continue medication."*

9 July 2008 – Discharged on standard CPA. CPA care plan: new key worker named as ward; no care co-ordinator named; Mr A to be contacted by telephone to arrange seven-day follow up but no telephone number noted for Mr A. Acute services care plan, signed by Mr A, gave his mother's telephone number: *"To contact and confirm on Thursday Mr A's whereabouts for his seven days follow up"*. Ward telephone number noted. CPA level not noted. Care co-ordinator not named. No evidence of risk assessment evaluation.

9 July 2008 - Notification of discharge form (completed by SHO2, signed by consultant psychiatrist 1) included: *"Diagnosis: Organic Hallucinosis ICD10 Code: F06.0; … community care plan: 7 day follow up by the CHTT; discharged home; continue medication."* There was no mention of a move to London, alcohol use, strokes, referral to older people's service or OPD appointment. See entry for 14 July for full discharge letter.

10 July 2008 - East sector access meeting minutes: *"Discharged to home address. Intends to start work in London on Monday 14.07.08. Fax to be sent to GP. Contact Mr A on 10.07.08 to confirm his whereabouts so as to arrange a 7 day follow up."*

14 July 2008 – Note made that ward staff attempted to contact Mr A by telephone to arrange seven day follow up but did not leave a message on the answer machine as they were not sure the number was correct. They were to try again tomorrow. The telephone number that staff tried was not recorded but the care plan of 9 July indicated contact was to be made via Mr A's mother.

14 July 2008 - Discharge letter to GP from SHO2: diagnosis: organic psychosis – hallucinosis ICD10 Code: F06.0. Medication included Aripiprazole, changed from quetiapine because of

dizziness, and epilim chrono. The letter described circumstances of his admission and his report of hearing voices telling him to "*kill them*". The letter said:

> *"While on the ward Mr A still expressed that he was hearing the voice coming from the right side of his head but agreed that he could control himself and that he was not going to act on these voices. The voices don't tell him to kill people around him that are very close to him but to go outside and kill others."*

The letter outlined results of EEG and said:

> "*These features are most likely due to the antipsychotic medication suggesting lower seizure threshold…On close observation on the ward, there was no evidence of Mr A responding to voices, although he admitted that the voices had decreased considerably and that the medication was working…Mr A was told of the consequences of carrying a knife and that it is a criminal offence. He improved whilst on the ward and he was happy to be discharged on his present medication…Past medical history: hypertension, deranged liver function test. Mr A had a stroke in 2004…Discharge Plan: Mr A was discharged home. He said he had a job in London and that he would be moving down to London; to continue his present medication; 7 day follow up by the CHTT; to contact the ward, if necessary; to see his GP as soon as possible.*"

There was no mention of MRI findings, second stroke, alcohol use, older people's referral or OPD appointment.

? July 2008 – Undated and unsigned entry on CPA form: "*Ward staff tried several times to ring him*".

15 July 2008 – GP record: "*aripiprazole 15mg tablets - 7 tablets - take one daily; epilim chrono 500 tablets (sanofi-aventis) - 14 tablets - 1bd; Medication review done (XaF8d).*"

16 July 2008 – Letter to Mr A offering outpatient appointment with consultant psychiatrist 2 for 12 August. Letter returned unopened marked "*refused*" on 24 July 2008. Handwritten notes on copy of letter: "*address correct with GP 28/8/08*" and "*not at this address*".

21 July 2008 – Mr A detained at police station under Section 136 of MHA. Mr A had presented himself at police station carrying knife and saying voices were telling him to kill someone. Police took him to mental health ward via A&E where he was assessed by consultant psychiatrist 4, another doctor and AMHP2. EDT report form gave his address as "NFA" with no telephone number shown and recorded:

"*Checked swift* [local authority database] – *known but not active…I was part of the team who assessed Mr A several weeks ago – he presented with exactly the same scenario as previously. Spent from 3 – 16 June as informal patient. Saying he was depressed and presenting as such with head down, shoulders slumped. He told us he hears a voice continually, often telling him to kill someone – anyone. Complained the voices were in the right side of his head, just behind his ear. He went to the Police Station 'voluntarily' – as he did before. He takes medication but said it is not helping. When asked to confirm his address, said he had now left the shared house he was in after an argument with the landlord and has been living in guest houses in Cleethorpes. Discussion with* [doctors] – *all felt Mr A was to some extent exaggerating his symptoms in an attempt to gain admission again. Ward staff held similar opinions.* [Consultant psychiatrist 4] *said his claimed symptoms do not fit with any regular mental illness. She is to send a letter via email to Mr A's GP, recommending changes to his medication, which she told Mr A will alleviate his voices, with minimal side effects.* [No evidence that letter sent to GP]. *Ward staff will request Crisis Team to arrange transport for Mr A back to Isaac's Hill where the guest house he has been staying in is located."*

A&E 'see & treat' form gave Mr A's usual address but a different mobile number. Nursing notes on this form: Mr A brought in by police under Section 136 and referred to crisis team. The section for medical notes was blank. The ward report noted Mr A was re-graded to informal after assessment by EDT and discharged.

21 July 2008 – GP record: "*A&E department attended (Y001c) - copy of A&E report that was deleted of patients notes re entered 19/06/09"*. No reason shown for attendance at A&E. Copy of A&E notification letter to GP in GP file about attendance on 21 July 2008 was dated 19 June 2009 and gave Mr A's address as the flat in Grimsby he moved to early in 2009. The letter said: "*The above patient attended the A&E department on 21 Jul 2008 at 17.47. The location of the event was Other. The complaint was ? voices in head…Diagnosis: NAD….Home – GP follow up"*.

12 August 2008 – Mr A did not attend outpatient appointment with consultant psychiatrist 2. New appointment for 7 October sent on 14 August. Letter returned unopened marked "*addressee has gone away*" on 26 August.

7 October 2008 – Mr A did not attend outpatient appointment with consultant psychiatrist 2. Prior to this appointment staff tried to contact Mr A on his mobile. Handwritten note on copy of appointment letter of 16 July said: "*has an appt for 7.10.08 – was it just sent or arranged with patient*". Also note of Mr A's original mobile number with words: "*Keep trying. 7/10/08 @11.00.*"

16 October 2008 – Letter to Mr A offering outpatient appointment with consultant psychiatrist 2 for 23 December. Handwritten notes on one copy of letter said: "*Serial DNA'er. 2 x New Ref appts DNA'd. No CCO*" and "*Spoke with GP surgery 17/10/08 gentleman still in town. GP still has this address.*" Another copy had house number changed by hand. Letter with new house number returned unopened marked "*return to sender, not known at this address*". GP record confirmed enquiry made about Mr A's whereabouts by mental health team.

31 October 2008 – GP record: prescription issued [but not seen by GP?]; "*Address changed from* [known address]; *Past Home Address* [Salvation Army Hostel in Grimsby]". [This was Mr A's new address which did not appear to have been passed to mental health staff].

18 November 2008 – GP record: Mr A saw GP about problem with foot. GP also recorded:

> "*Mental health review (XalyU) – Complying with his medication. Symptoms controlled. No regular follow up needed unless he relapses. Has a key worker in Salvation Army, short term plans to resettle to shared house, go on a course and get employment, good insight. Has got friends. No use of illicit drugs. Alcohol currently nil. Organic psychoses NOS (E0z..) – no more psychosis symptomatology, no hallucinations or delusion, kempt, normal mood, good insight, not carrying a knife, is complying with his repeat medication and feels that this is controlling his symptoms satisfactorily. Not working at the moment, plans to start a course, move to a shared house, hopes to get into employment soon. Nondependent alcohol abuse (XE1YX) – well controlled, no cravings, no alcohol in morning, twice a week, drinks 16 units per week. Medication review done (XaF8d).*"

22 December 2008 – Mr A saw staff at GP practice about his feet.

23 December 2008 – Mr A did not attend outpatient appointment with consultant psychiatrist 2 but letter of 16 October had been returned, so Mr A was not aware of appointment. There was no further follow up.

Christmas 2008 – Mr A made contact with his family after being out of contact since summer 2008.

January 2009 onwards – Mr A had more regular contact with his family.

6 February 2009 – Mr A moved to flat in Grimsby.

13 March 2009 – Mr A saw staff at GP practice for smoking cessation advice.

20 March 2009 – Medication dispensed: epilim, simvastatin, aspirin, aripiprazole, enalapril maleate, co-dydramol. The boxes were found in Mr A's flat following the incident. All the boxes contained some medication.

The months prior to incident – Mr A visited his family. He appeared fine but quieter than usual. He spoke positively to his family about his improved job prospects. He told his mother he had "*passed a forklift truck course and had also done English and Maths*".

4 days before incident 2009 – Mr A attended A&E with a foot injury. His foot was x-rayed. The diagnosis was given as "*contusion, foot*". He was given advice and discharged.

Day of incident 2009 – Mr A arrested on suspicion of murder. Assessed by consultant psychiatrist 2, a police doctor and AMHP2 who recorded: consultant psychiatrist 2 felt Mr A not psychotic but mentally ill, possibly dangerous to others and not fit for interview. Plan: keep in custody overnight and take to court in morning with request for remand to secure mental health unit.

Day after incident 2009 – Letter to GP from consultant psychiatrist 2 following assessment the previous day. Consultant psychiatrist 2 obtained information from mental health records, including changes to right parietal lobe. The letter said:

"When Mr A was brought to the assessment room he was apparently disturbed, anxious and fidgeting. He did not develop good eye contact, he kept his face in his hands and when we asked the first few question, he was able to engage in the conversation and was giving quite clear and reasonable answers. He confirmed that he has been hearing voices for about a year at least and he was on both [mental health wards]*…Following these hospital admissions he was never followed up by mental health services however he was treated for the voices in his head and he received tablets for it from his GP…for the last few days he felt worse and his voices were more disturbing, however he did not contact anyone about it and he did not approach the mental health crisis team for services even though I understand he was aware of such possibility. When questioned about the voices he explained very clearly and without any doubt that he can hear one male voice in his head and he was clear that it was not from the outside world, it is in his head and it is telling him to kill somebody. He could not explain why he was able to resist the voice for the last year and then why he actually stabbed a person today.*

" He admitted to drinking alcohol today and he had 2 pints of beer. He confirmed that he drinks alcohol not every day but quite regularly - up to 4 pints of beer per day on average however he was quite adamant that he does not have a drink problem and he denied using any illicit drugs either. During this assessment the patient was apparently distressed and he confirmed feeling low and anxious. He was quite upset and expressed his anger about not having been treated properly as he said he needed help a long time ago and no appropriate help was offered to him. He was happy to dwell on the lack of appropriate support however he was not interested about what happened with the victim of his attack. He did not ask any single question about the victim…he needs to be detained under Section 2 for appropriate assessment as we were not clear in terms of the specific diagnosis as the voices he relates to are described not as typical auditory hallucinations and in respect of the organic changes in his brain, we thought that he needs thorough assessment of his mental state."

Following discussion with police it was decided to detain Mr A at the police station to be charged, even though he could not be interviewed. He would go to court for a decision about further psychiatric treatment.

3 weeks after incident 2009 – Consultant psychiatrist 1 prepared a report following the incident. He gave an outline of the two admissions, progress on ward, tests and reviews. He mentioned Mr A's reference to two mini strokes; CVA in 2004; right infarct in 2004; repeat scan in 2007 showing no new pathology and MRI in June 2008 showing the old left infarct. He mentioned the EEG with features most likely due to antipsychotic medication; referral to older people's service; no evidence of responding to voices; Mr A said medication helping to reduce voices.

> *"Mr A was assessed by psychologist,* [psychologist 1], *there were no psychological problems noted.'*

The report said Mr A was informed about the decision that he had capacity. He was reviewed on 9 July 2008 after two days leave; he had consumed no alcohol during leave; auditory hallucinations were under control; discharged.

> "*We could not confirm objectively any abnormality in his perceptions…unable to detect any form of mood disorder, adjustment reaction or behavioural problems …evidence base presented in his blood test, together with presentation before admissions revealed alcohol problems…described by Mr A, symptoms belong to disorders of perceptions, rather pseudohallucinations than hallucination…clinical picture…seems close to alcoholic hallucinosis…right middle cerebellar infarct…and old left posterior frontal infarct haven't had confirmation in his clinical picture… EEG showed several episodes of mixed, low and sharp components…patients with complex partial seizures often have difficulty in describing the experiences. Typical features…are disturbed perceptions, visual auditory…Organic findings and organic intoxications by using alcohol was the reason for referral to a specialist service who deals with organic disorders. All relevant information about The Junction has been discussed and given to him together with the recommendation that he must stop alcohol completely."*

2010 – Mr A was convicted of murder and sentenced to life imprisonment with a minimum period of 20 years.

Appendix B

Documents reviewed

Clinical records

Emergency duty team records
Crisis follow up records
Community mental health team records
North Lincolnshire & Goole NHS trust records
Forensic mental health records
'Green' inpatient mental health records
General practitioner records

CTP internal investigation documents

CTP internal investigation report
CTP timeline of action taken following incident with supporting documents
Action plan from CTP internal investigation – updated by NAViGO August 2011

CTP and NAViGO policy documents

Care programme approach policy – April 2004
Adult protection policy – August 2003
Incident reporting policy – March 2007
Records management policy – January 2005 ratified January 2008
Mental health directorate clinical risk policy – July 2009
Mental health directorate clinical risk procedure – December 2009
Mental health act 1983 section 136 joint agency protocol – March 2007
NAViGO discharge policy – April 2011
NAViGO overarching operational policy – May 2010
NAViGO acute adult mental health psychology policy – April 2011

Other documents

Professional review of NELCTP psychology services – December 2007
Leaflets on how to refer to CTP psychology service – two undated, one dated August 2009
Record keeping: guidance on good practice from British Psychological Society – April 2008
Correspondence between psychologist 2, SHA and CTP
Correspondence between psychologist 2 and Verita

Appendix C

Biographies

Sue Bos

Sue is based in the north of England and is a graduate of the NHS national training scheme. Sue spent most of her career working in hospitals in senior operational roles, and was director of specialist services at Leicestershire Partnership NHS Trust for many years. In this role she was responsible for a group of clinical directorates, which included forensic psychiatry, psychotherapy, drug and alcohol services and child and adolescent services. Throughout this time, she was a member of the trust's senior management team and undertook many investigations and reviews. She has also carried out work as an independent consultant at the National Patient Safety Agency and for the Health Service Commissioner. Sue has completed a number of investigations for Verita, most recently, two independent management reviews relating to Baby P.

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

Dr Mike Dilley

Mike Dilley is a consultant neuropsychiatrist and the inpatient clinical lead at the Lishman Unit, Maudsley Hospital, London. Before taking up his role at The Maudsley, Mike worked as a consultant psychiatrist for five years in inpatient and community services in the London Borough of Westminster, where he was also the Care Quality Lead for two large inpatient services. Mike competed his training at The Maudsley and The National Hospital for Neurology & Neurosurgery. His clinical work includes leading a neurorehabilitation team in the management of adults with acquired brain injury, the management of

complex functional neurological conditions and other neuropsychiatric presentations of neurological illness. He is an executive member or the Section of Neuropsychiatry, Royal College of Psychiatrists.