2008

Report of the Independent Investigation into the Care and Treatment of B - SUI Reference 2005/95

A report prepared for Yorkshire and the Humber Strategic Health Authority by Caring Solutions (UK) ltd

Presented to the Board of Yorkshire and the Humber Strategic Health Authority – May 2009

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Introduction

On 5 January 2005, B, a male out-patient in receipt of psychiatric services, fatally stabbed a 31 year old woman in the street. She was unknown to him and was 31 weeks pregnant with twin boys.

B remains detained in a High Security Psychiatric Hospital. He is likely to remain so for a considerable period of time. He is much improved because he is receiving medication which can now be consistently monitored over a prolonged period of time and he is involved in meaningful day time activity. He still has no recollection of the events of the 5th of January 2005.

Following this incident the Mental Health Trust (MH Trust) quickly established an internal inquiry led by a group of senior staff. The report made a number of recommendations which informed an internally generated Action Plan adopted and developed by the MH Trust over the past two years.

The internal report was thorough, objective and fair and made criticisms as it saw fit. The MH Trust has responded to identified developmental needs and the independent investigation team report examined these in detail.

The Internal Investigation

The independent investigation team concurred with the internal investigation which found the following:

1. There was a consistent pattern of admission of the patient followed swiftly by a pattern of increasing leave, with returns from leave and the outcome not being consistently recorded in notes. Carers views were not routinely sought during or following periods of leave. The patient spent a lot of time on leave even though he was documented as being unwell.

2. In view of the severity of his illness more weight should have been given to formal admission.

3. Admission risk assessments were cursory and failed to examine the chronology of events leading to the admission or the previous history.

4. There was no record that risk issues were routinely discussed at the inpatient multi-disciplinary team meetings and did not appear to have been fully taken into account.

Treatment

The internal investigation report's findings and conclusions in the area of treatment encapsulate the majority of the core issues pertinent to the patient:

1. It was apparent that B was difficult to engage. He was reluctant to accept that he was unwell, disliked being in hospital, was poorly compliant with medication and would not fully communicate with professionals.

2. There was a consistent theme of non-compliance with prescribed medication particularly when he was unwell. A comprehensive substance misuse history was never taken although there continued to be queries concerning drug induced psychosis

3. A full 'Carers Assessment' should have been undertaken at the outset and reviewed annually. There was no evidence that this took place and it was not clear who should have taken the responsibility for organizing this.

Engaging the Patient

Despite the patient's reluctance to receive treatment the independent investigation team found those responsible for his mental health care did respond when alerted to his deterioration when living at home and on balance took action to alleviate his and his carer's immediate distress.

This was achieved by:

- Consistent outpatient support being offered and delivered, as was the domiciliary visiting to administer medication.

- His mother was invited and attended inpatient care planning meetings and outpatient appointments.

The Independent Investigation

The independent investigation team acknowledges that it was very difficult to obtain a full picture from B of what his symptoms were and how they affected him. He was skilled at masking and hiding them from staff and said what he thought they needed to hear in order to simply be left alone.

As an inpatient he kept himself as anonymous as he could. He was therefore genuinely difficult to engage.

Having considered all of the above aspects the independent investigation report concluded that the root cause contributing to the patient's continuing severe mental disorder was that of 'under treatment'. His situation and condition could and should have been more assertively managed.

The main contributory factors were:

- The patient dictating, in part, elements of his treatment which should have fallen within the auspices of professional practice.
- Of the six admissions he had over a four year period only one, which was of a prolonged duration where he had been compulsorily detained, had a more noticeable effect on his mental state.
- There was little attention paid to the testing for the presence of illicit drugs and no thorough history of his illicit drug use.
- He too rapidly proceeded to leave when an inpatient.
- He was able to abscond and absent himself from inpatient care too easily.
- He had little to occupy him through the day in a structured programme when at home.
- Alternatives to living at home were not considered or pursued with any vigour.
- The needs of his mother and how her relationship with her son and how tensions between them could be helped were not assessed and considered early enough.
- There was no thorough social history taken of his life.
- The admission in November 2004 was on the balance of probability a missed opportunity to compulsorily detain him , consider alternative medication and monitor its efficacy in a controlled environment. Previous admissions had little clear purpose apart from that of a reactive response to his mental state presentation.
- The Risk **A**ssessment documentation available at the time was not used to its full potential.

Having considered the above findings the external investigation team concluded the following:

The Mental Health Trust investigated the homicide in a timely, thorough and appropriate manner and was critical of their practice and took appropriate steps to rectify identified deficiencies. The service structure, procedures, and monitoring systems have addressed the gaps identified and has significantly moved on since 2005.

The Mental Health Trust

The MH Trust currently provides specialist mental health, learning disability and addictions services to a population approaching 600,000 with an annual turnover of some £80m. The Annual Plan is shaped by a new strategic direction for the MH Trust as it moves to Foundation Trust status. During 2007/08 the MH Trust acquired, in effect, a new Trust Board with the appointment of a new Chairman, Chief Executive and Non-Executive Directors. A new post of Director of Human Resources and Diversity has been developed to take forward the Trust's workforce strategy.

The Healthcare Commission Reports of 2006 - 2008

These reports of all the 69 NHS trusts that provided mental health acute inpatient services over this period of time were allocated scores against certain assessable criteria. The Key used is 1, Weak; 2, Fair; 3, Good and 4, Excellent. The MHTrust scored 3, Good in 2006/2007. In 2007/2008 the Trust scored 4, Excellent. For both periods the Trust scored 3, Good, for its use of resources.

Of particular note specifically relating to the MHTrust was the score of 4, Excellent, for the clinical supervision and ward manager leadership development.

Service Developments

The independent investigation team found that the service had moved forward in a positive direction and the key developments are described in the main body of the report, recommendations are made from these and examples are as follows.

In 2007/08 the Trust achieved implementation of a major 'whole system model' service redesign resulting in improved adult mental health services with a single point of entry and initial assessment. This has brought greater clarity of service provision, in particular that of home care networks supporting families.

Use of the Care Programme Approach is much improved as are the keeping of records

Provision of intensive care facilities are much improved

A 'Galatean Risk Screening Tool' (GRiST) is now in use by the adult mental health services. This decision support system for mental health professionals has been developed by the Universities of Warwick and Aston, funded by the Department of Health.

1. Introduction

The external investigation team sincerely hopes that the contents, observations, findings and broad recommendations made in this report offers some resolution and closure to all parties involved in this tragic event.

1.1 On 5 January 2005, B, a male out-patient in receipt of psychiatric services, fatally stabbed a 31 year old woman in the street. She was unknown to him and was 31 weeks pregnant with twin boys

1.2 B pleaded not guilty to her murder, but guilty to her manslaughter on the grounds of diminished responsibility. There was a period of time when he was considered unfit to plead. His eventual plea was accepted by the Crown Prosecution Service. On 5th May 2006 the Crown Court Judge disposed of the case by way of a Section 37 Hospital Order with added restrictions under section 41 of the Mental Health Act, 1983. The restriction order is without limit of time. He is currently detained and being treated in a psychiatric hospital under conditions of high security.

1.3 Prior to the homicide he had been living with his mother and her long standing partner, with whom he had a good relationship. At the time of the offence he was 23 years old. Since the 11th September 2001 he had been treated by the local psychiatric services (referred to throughout this report as the MHTrust) under the direction of the same locum consultant psychiatrist and had a diagnosis of paranoid schizophrenia.

2. The Review Panel

Dr Colin Dale	Chief Executive, Caring Solutions (UK) ltd Panel Chairman
Dr Michael Rosenberg	Consultant Psychiatrist Sussex Partnership NHS Foundation Trust
Mr Peter Green	Senior Psychiatric Social Worker Caring Solutions (UK) ltd

3. The Internal Investigation

3.1 Comments taken from the internal investigation are captured in *italics* in this report to distinguish that reports commentary from that of this independent investigation.

3.2 Following this incident the MH Trust quickly established an internal inquiry led by a group of senior staff, chaired by the then Nurse Director. This group devised a communication plan for those various agencies and staff that needed information on how this homicide was to be handled and the consequent developments were to be monitored; preparation for the internal investigation and how to deal with their immediate findings and conduct regular reporting to the MH Trust's Board.

3.3 The internal review team appointed consisted of a Director of Integrated Mental Health Services from a Trust external to that under review; a Clinical Director and Consultant Psychiatrist; the Head of Services, a Principal Manager with specific links to the local authority from the Trust. This team also included a Non-Executive member of the Board. Their final report was dated the 18th April 2006. It made a number of recommendations which formed the Action Plan adopted and developed by the Trust over the past two years. The internal investigation team conducted a thorough examination of the patient's contact with psychiatric services

3.4 Complimentary to the internal review a Modern Matron and Team Manager were rapidly commissioned to develop a 'time line' associated with B's involvement with the MH Trust's services. This report was made available on 20th January 2005 and aided the internal and external review teams.

3.5 Both of these reports were thorough, objective and fair and the internal review made criticisms as it saw fit. The MHTrust has responded to identified developmental needs and this independent external report comments on these later.

3.6 Briefly the action plan adopted addressed the following areas:

- Leave and Section 17 leave.
- Drug Screening.
- Risk Assessments (previous history informing care plans).
- 'Carer Assessments'.
- Recording of Multidisciplinary Team Meetings and record keeping.
- Communication.
- Engagement- with patients difficult to engage.

3.7 The group of senior managers met regularly from the 10th of January 2005 until the 12th November 2007 and was resumed to respond to the independent investigation and resulting recommendations and is now

being headed by the Medical Director. As a group they responded appropriately and rapidly to the situation. They are to be congratulated on the consistency of their efforts and the detailed minutes they kept on their actions taken reflected their concerns to learn lessons.

4. The Independent Investigation.

4.1 On the 27th June 2008 the Independent Investigation Team (the Team) met with representatives of the Strategic Health Authority, the MH Trust, the Teaching Primary Care Trust and other interested parties. Terms of Reference were agreed as were timescales and the provision of monthly up-dates.

4.2 The Team noted they would, as far as was possible, follow the 'Good Practice Guidance' produced by the National Patient Safety Agency (February, 2008) for conducting such investigations. The Team also advised that when considering risk the Royal College of Psychiatrists report 'Rethinking Risk to others in Mental Health Services', March 2008, would be taken into consideration. The approach taken is described later although much of it was shaped by the Terms of Reference.

4.3 Under the guidance issued in HSG(94)27, as amended in June 2005 (paragraph 33-36) and August 2007 the Team were commissioned by the Strategic Health Authority, who were obliged to do so, to investigate the care and treatment of a service user of specialist mental health services where, following due process of law, a finding of guilt for the homicide has been determined. Such investigations are required to address areas identified in the following Terms of Reference:

5. The Terms of Reference.

5.1 Terms of Reference for Independent Investigation (2005/95) were set by NHS Yorkshire and the Humber Strategic Health Authority (SHA) in consultation with the local Mental Health Teaching NHS Trust and Teaching PCT and the independent investigation team

5.2 The investigation was required to address:

- The care and treatment the service user was receiving at the time of the incident (including that from non-NHS providers e.g. voluntary/private sector if appropriate);

- The suitability of that care and treatment in view of the service user's history and assessed health and social care needs

- The extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health and local operational policies;

- The adequacy of the risk assessment and care plan and their use in practice;

- The exercise of professional judgment and clinical decision making ;

- The interface, communication, joint working and consistency between all those involved in providing care to meet the service user's mental and physical health needs;

- The effectiveness of specialist services utilised in the provision of care, i.e. alcohol services.

- The extent of services' engagement with carers and the impact of this.

- The Quality of internal investigation and Review.

Also to identify:-

- Learning points for improving systems and services;
- Developments in services since the user's engagement with mental health services and action taken since the incident.
- To consider if any omissions or issues identified in the investigation of the incident remain unresolved.

To make:-

- Realistic recommendations for action to address the learning points to improve systems and services.

- To report these findings and recommendations to the Board of Yorkshire and the Humber Strategic Health Authority.

5.3 The item added for the consideration of and comment on developments in service since the homicide was added as there would be a public expectation that lessons learnt from this tragic event for all concerned had moved the services on.

6. Guidance to Independent Investigators

6.1 The guidance developed by the Strategic Health Authority lays out the procedure for such investigations. The administrative requirements were met. The investigation has no legal status and witnesses are not compelled to attend for interview or provide a statement and agencies are also not compelled to provide documents. Of particular note is the style to be adopted with the main principle of promoting fairness to all involved in this process: the involvement of the service user's family and the victim's family and the sensitivity with which this is dealt with.

7. The Conduct of the Independent Investigation.

7.1 It will be apparent from the above that the terms of reference set out in part the procedure which was to be adopted. We began by obtaining B's consent to the release of documents relating to his care and treatment and also to his subsequent conviction in Crown Court. The local police officers who conducted the homicide investigation made themselves available and provided valuable records giving an excellent account of events. Pre-trial assessment records from the high security hospital were thorough and helpful in giving an insight into his mental state post arrest. The social history produced by the senior social worker at the high security hospital helped give insight into B's personal views on his life and mental illness. The documents provided by the Trust included his medical records and nursing notes which are extensive because B had a significant amount of contact with the psychiatric services under review for four years. There were a smaller number of documents held by the local authority. The Trust's policies and procedures pertinent to that time were available on disc. The Trust's Annual Plan for 2008/09 was considered and the Team was greatly assisted by a separate document produced by B's consultant psychiatrist.

7.2 Using the above documents and with the assistance of the local NHS Teaching Primary Care Trust, who provided the 'Lead Co-ordinator' administrative support and advice to the Team, we listed those whom we considered were likely to be able to give relevant observations to the Team. Letters initially putting staff on early notice that the Team would wish to interview them were sent. These were later refined to notify those finally invited to attend of the areas to be covered relevant to their input into B's care. Attached to these letters were the terms of reference, how the Team were to proceed and its membership. Staff invited agreed to attend and after assurances were most helpful and open in their responses.

7.3 It was apparent that the history of B's care and the decisions made about his care which were material to the investigation could be ascertained to a significant degree from the documents with which we had been provided. Furthermore, throughout, we have placed considerable importance and emphasis on the need to look to the service developments post 2005 events. To this end we were keen to avoid interviewing a proliferation of staff whose evidence had in the main been given to the internal inquiry. We therefore invited largely only the senior clinicians in B's care who could expand upon the information available to us in an attempt to ensure the facts we were told were germane and proportionate to the issues we were asked to consider.

7.4 On 6th August, 2008, two members of the Team visited the units now operating in the newly reconfigured inpatient assessment ward, continuing treatment facility and the psychiatric intensive care unit (PICU). The treatment facility in the community location was of particular interest as this was a unit close to B's home where much of his inpatient care in the latter days prior to the offence was provided and planned. We were able to talk with staff who had nursed B. We comment on the arrangements of these units later.

7.5 On 7th August, 2008, B's mother was interviewed in her home. Again, we discuss our impressions of her and provide her comments on her son's illness and his treatment later in the report.

7.6 On the 9th of September, 2008, B was interviewed in the high security psychiatric hospital.

7.7 The Team heard from staff on the 10th and 11th of September, 2008. They were; the current Medical Director of the MHTrust, the Consultant Psychiatrist responsible for B's care and treatment for all the time he was in receipt of mental health services from the MHTrust, B's Community Psychiatric Nurse, an Approved Social Worker from the local authority and the MHTrust's current Risk Manager.

7.8 Following the above visits, reading the documentation and interviewing staff a draft report was prepared. This draft was provided on a strictly confidential basis to the commissioners of the independent external investigation and other key agencies, and they were invited to make such responses as they considered appropriate. Some amendments were made to the report as a result of the helpful responses which we received and for which we were grateful.

7.9 This report concludes with our recommendations. They have been through the same process described above. We hope these are of help in endorsing the overall service developments taking place within the MH Trust and in particular helps the public maintain confidence in the services provided and encourages staff as it nears Foundation Trust status.

8. The Patient, B.

8.1 B was born on the 8th February 1981. It was a difficult birth and B suffered distress. He was delivered by emergency Caesarian. B has no contact with his natural father and up to the offence he lived with his mother and her partner of twelve years standing.

8.2 His mother describes him in his early years as a hyperactive child; he had bags of energy and was into everything. He had a large extended family and spent lots of time with them. At primary school he was bright and able although he had little self confidence and this is thought to have been caused by bullying at school when he was around seven to eight years old. His mother knew little of this until he ran away one day with a friend. At the age of nine he reports his weight began to dominate his life. He was unable to talk about this and stated it was not in his character to speak out.

8.3 At high school his weight became even more problematic and he was subjected to a lot of verbal abuse. He was petrified of three boys in particular and regularly gave one of them his dinner money.

8.4 He gained four GCSEs and attended college gaining A level passes in Law, History and Politics. In 1998 as part of his A level studies he attended the local Crown Court to see a live trial. During the trial he began laughing and was held in contempt of court and was fined £100. This was his one and only conviction.

8.5 At the age of seventeen/eighteen he was eventually persuaded to take Ecstasy by his friends. He felt it enhanced his life in that it gave him confidence to talk to people and he felt he was more extrovert. He took Ecstasy on and off for the next three to four years. He increased his intake to two tablets on Saturday nights. On one occasion in 2000 he recalls taking 4 to 5 tablets at once

8.6 In September 2000 he commenced law studies at a university in London and in August 2001 he visited his aunt in London and asked her if there was anything wrong with his face as something had

happened in his head which had affected his face. He began to lose interest in the course and spent weekends traveling home.

8.7 On 18th of August 2001 he was admitted to a medical ward in a London hospital after an overdose of 32 Paracetamol tablets. The following day his mental state examination indicated a history of passivity phenomenon, thought insertion, thought withdrawal and persecutory delusions.

8.8 On 20 August 2001 he was admitted to a psychiatric hospital in London. On the 27th of August, whilst still an in-patient, he was brought to an A&E unit stating he had taken another overdose. He reported feeling agitated and was experiencing impotence; he had thought block and continued to express passivity phenomena. His transfer to his home area was negotiated.

8.9 On the 11 August, 2001 B was transferred to an acute psychiatric in-patient unit near his home address. If he tried to leave it was noted that he should be detained under the Mental Health Act, 1983. This was the first time he came under the care of the MH Trust.

8.10 On the 13th of September until the 17th of September B had his first period of home leave to his mother's address. He returned having taken no medication for three days and agreed to restart Olanzapine. He had further periods of leave and was discharged to the care of his GP and the Community Psychiatric Nurses (CPNs). On discharge his diagnosis was that of 'drug induced psychosis predominately delusional'. He gained over two stones in weight on Olanzapine.

8.11 He was seen in a psychiatric outpatient clinic on 19 December, 2001 where he appeared well. He was given a further review date of 24th of April, 2001. However on the 11th of March he was visited at home in response to a call from his mother to say he was becoming unwell. He was more agitated and pre-occupied with anxiety thoughts. On 22 March he attended an outpatient meeting with the consultant psychiatrist caring for him. His Olanzapine dose was increased to 20 mgs as it had been noticed he had been agitated, suspicious and negative and at the previously arranged appointment for the 24th of April he appeared well and was concerned re his weight gain. As a result of his concerns about weight his Olanzapine was reduced to 15mgs.

8.12 Apart from the brief period in March 2001 he appeared well from October 2001 until November 2002, a period of over one year.

8.13 On 11th November 2002 he was visited at home by his CPN as a result of concerns raised by his mother. He appeared agitated, deluded and paranoid. He talked of a friend controlling his thoughts and life. According to the CPN notes he spoke about killing this friend and then all would be well. He went on to tell the CPN that he had been on a date some weeks previously and that he felt he could have raped the girl and that he felt possessed. He was admitted informally to hospital that day. There is a single note on admission that he felt he could kill someone. A positive urine amphetamine test was taken on this admission and he was advised of the negative effects on his mental health.

8.14 He was on leave to his home some two days later for three days and was discharged on the 20th November 2002.

8.15 He was seen in out-patients on 20th December, 2002. He had stopped taking his medication because of weight gain and self reported occulogyric crisis. He agreed to a change in medication to Risperidone.

8.16 In early February, 2003 the CPN had a discussion with B concerning his diagnosis which had now been decided to be that of paranoid schizophrenia. Without doubt this diagnosis had a most profound impact on him, which lasts to this day. Access to the internet gave him information concerning this devastating permanent mental illness. He had convinced himself that, if anything, he had borderline personality disorder.

8.17 On the 17th February, 2003 he had a discussion with his CPN on the phone. He complained of anxiety, restlessness and insomnia. Following discussion between the CPN and a staff grade psychiatrist his medication had added to it Procyclidine and Diazepam for the next five days. This enhanced prescription was faxed to his GP.

8.18 That same evening B was admitted to a local general hospital having taken an overdose of Paracetamol, Procyclidine and Diazepam. Two days later he was transferred to an acute psychiatric unit from which two days later he was given leave from which he refused to return. He was seen on 25 February, 2003 and was discharged home. Again he decided to stop taking medication on a regular basis and re-commenced on or about the 1st of April.

8.19 On 24th April B was seen at home by the CPN following a telephone call from his mother who reported that the previous day he had gone missing and was returned home by the police. He had stopped taking medication again some two weeks previously. He had had some form

of panic attack when out and had asked a stranger for help. The continuing cause of his distress was described as his diagnosis. He went missing again on the 25th April and was subsequently located at the local A&E.

8.20 On the 27th April he was detained by the police pursuant to Section 136 of the Mental Health Act, 1983. He had been found wondering in the streets semi naked as he wished to be "naked in the sight of God". He had defecated in the street. He was mute, but responded by shaking his head. He was admitted under Section 2 of the Mental Health Act, 1983 to an acute psychiatric unit and was placed on 15 minute observations, but absconded and was found semi-naked in a derelict building. It required police assistance to return him where he remained distressed, refused medication and punched a nurse in the face. In his room he remained distressed and naked. He was moved, with the help of the police to a more intensive care unit where he remained unwell for a period was agitated, anxious, isolative and verbally aggressive. He neglected himself, was difficult to engage and refused medication.

8.21 He was regraded to Section 3 of the Mental Health Act, 1983 on 15 May, 2003. A note in his medical records indicated that if he continued to not comply with oral medication then a depot would be considered.

8.22 Between June and July his mental state slowly improved and this coincided with better compliance with medication. However he continued to intermittently abscond from the ward and was not fully engaging with staff.

8.23 On 17th July, 2003 whilst on unaccompanied, but approved leave, he failed to return and was picked up by the police on the motorway walking towards the local airport in attempt to get to New York.

8.24 On 26th August he was discharged from the Section 3 order detaining him and was discharged from in-patient care on the 25th September 2003. He was seen at out-patients on 27th November, 2003. It was recorded he had stopped taking medication three to five weeks previously. He denied any psychotic symptoms but refused to let his mother be seen.

8.25 On 17th December 2003 he was seen once again in out-patients. His consultant psychiatrist recorded a 6-8 week history of thought broadcast, thought withdrawal, second person auditory hallucinations and persecutory delusions. He appeared to be laughing inappropriately and complained of people talking to him from his CD.

He was not taking any medication. He was admitted to hospital as an informal patient where he was observed to be evasive, hostile, paranoid and restless. He was distractible, guarded and suspicious. He attempted to leave during the assessment and was reported to be responding to hallucinations to have thought broadcast and to exhibit odd behaviour and gestures. He was placed on 15 minute observations. He smashed the door surround to his bedroom and remained difficult to engage over the next few days. He was hostile and intimidating to staff but not directly a threat. He absconded on 20th December, 2003 being brought back by a ward porter and thereafter on another two occasions. There were difficulties in gaining his permission to take medication on any consistent basis. On 11 January, 2004 he began a period of overnight home leave despite being unwell and verbally aggressive.

8.26 On the 27th January it was noted at a multi disciplinary team meeting (MDT) there was not much improvement in his condition and was granted leave despite remaining unwell and on 3rd of February he was granted leave at the nurses' discretion. On 24th of February he commenced on depot Zuclopenthixol (test dose) and by the 9th of March he was on 300mgs fortnightly. He was discharged on the 6th of April and remained reasonably well despite reported occulogyric crisis and minor adjustments to medication until 3rd of November, 2004.

8.27 On this date B's mother contacted his then CPN to report that B was unwell. The CPN visited home to find B deluded and behaving oddly by praying out loud. His consultant psychiatrist visited him at home with a local authority Approved Social Worker (ASW). The record of the assessment was that his mother stated her son had been irritable, suspicious, verbally aggressive and praying to the fridge. He appeared actively hallucinated, was insightless and stated that he would cure himself by praying. He became increasingly threatening and demanded that the consultant and ASW leave within 60 seconds and began to count backwards. They did so with the advice to his mother that an admission under Section 3 would be commenced. In the meantime if the situation deteriorated she was to call the police.

8.28 Later that evening he was seen by the duty consultant psychiatrist and a duty ASW. They did not know B and did not have the benefit of access to his notes. Accompanying them was a health care assistant who had nursed him previously. They were retold by his mother that he had been praying excessively in front of the open fridge door to ask the Holy Spirit to protect him. B informed the ASW that the Holy Spirit had told him he (the ASW) was evil and that he had to crack his skull. B managed to restrain his symptoms for a while before becoming intensely aroused and accused the accompanying nurse of being evil.

The duty consultant recalled B as being one of the most poorly people they had seen.

8.29 B, however, agreed to enter hospital voluntarily, with the proviso he would only stay one night. Medical recommendations were made for him to be detained. The risk assessment form in use at the time was completed and recorded the main risk indicators overall as; hostile, guarded, aggressive, using illicit drugs, disengagement with services, having no insight into his situation and no treatment compliance and a history of overdose. The independent investigation team had major doubts concerning his capacity to give properly informed consent at that time.

8.30 He telephoned his mother early the following morning to come and take him home. His mother rang the unit to enquire why he had not been detained under Section 3 of the Mental Health Act, 1983 as she had been led to believe would have happened.

8.31 On the afternoon of the 4th November he absented himself from the unit by using a chair to climb over the garden wall of the unit. The consultant psychiatrist requested an ASW assess to make application for detention on B's return. He returned by ambulance later that evening. He had caught a train and had got off shortly after and had called the ambulance as he was unwell.

8.32 On the 5 November he was seen by the same ASW for assessment to make application for detention under Section3 thereby activating the medical recommendations. On assessment B presented as calm and much better. The ASW declined to make the application. The ASW notes indicate that B was informed that if he absconded from hospital again and staff had concerns regarding his safety a further assessment may take place.

8.33 Following periods of home leave he was discharged from hospital with the usual home visits by the CPN to administer depot medication and with follow up out-patient appointment on 6th January 2005. It was at this time that B and his mother were to be offered family therapy to explore the high expressed emotion which B felt affected him at home.

8.34 On the 7th of December 2004 another CPN saw him at home to administer his depot injection and B presented as being stable with no evidence of any significant further new symptoms. On the 21st of December 2004 his regular CPN visited for the purpose of giving the depot injection and once again there were no adverse issues. His CPN completed a risk and relapse plan.

8.35 On 4th January 2005 he was visited by the CPN and there was no reply. A telephone conversation with B's mother clearly indicated that he was avoiding having the injection that day as he now believed he could be cured by prayer and deceived his mother with false information as to why he was not to receive his depot injection for another week. He had previously skillfully avoided his mother's involvement in his treatment, one example being that he would arrange for the CPN to visit when his mother was at work.

8.36 An appointment was made for B and his mother to see the consultant psychiatrist accompanied by the CPN the following afternoon, the 5th of January 2005 a day before his appointment arranged at the end of November 2004. B, after discussion with the consultant agreed to have the depot injection, which was increased. Documentation indicates that it was believed he was becoming unwell again and was relapsing. His mother indicated as such and he had during the interview smiled inappropriately, although briefly and only twice, to himself. There certainly was no indication of the events which had occurred that morning prior to this appointment.

8.37 B still to this day has no recollection of events and denies that he committed the offence. When members of the Team interviewed him in the high security hospital he re-stated this position and noted that he only pleaded guilty to have the court hearing out of the way.

8.38 B was captured on several different CCTV cameras operating in the area. He was recorded taking a kitchen knife from a local store, discarding the wrapping and the fork which was part of the set and secreting the knife. His victim and B were seen by an eye witness who subsequently identified him, he was seen by another witness, who knew him in that area and there was the compelling evidence of his DNA on the knife abandoned at the scene.

8.39 There was no evidence to suggest that B knew the deceased prior to the offence.

9. Visit to the High Security Hospital

9.1 We are grateful to B's current Responsible Medical Officer (RMO) who made herself available to us for discussion and to the staff who courteously facilitated our visit

9.2 Since admission to the High Security Hospital his mental state was greatly improved. His medication had been changed and with the opportunity to consistently monitor its effect and because of his

9.3 He was specifically asked his views on his treatment by the MH Trust.

9.4 His views and comments were:

- He had not fully told staff what they needed to know to help him.
- He had told his consultant and nurses what he thought they needed to hear in order to let him out of hospital by granting leave.
- It was far too easy to abscond and leave the units he was admitted to.
- He had been constantly plagued by 'aliens' and lived in a state of fear of them; on occasion he was terrified. Much, if not all, of his absconding was to get away from them. When he was found wondering far away from home it was to escape these thoughts, which he was unable to do. He shared little of these thoughts and the impact they had on him although he did with his mother.
- He could negotiate with too much ease changes to his medication.
- He was frightened of patients on the units he was admitted to.
- On reflection, and now considering his situation, he wishes he had been more assertively treated.

9.5 He still has no recall of events and the one specific question we asked him was concerning his possible access and use of street drugs that day or the day before the offence and his response of, "none were available that day." indicated to us the possible continuing use of illicit drugs around that period, (there was no evidence of routine drug screening despite ongoing inference that drug use played a part in his presentation when an inpatient of the MH Trust).

9.6 We were left with the view, despite the rapid improvement in his condition, that until he can be open with staff concerning his thoughts and his index offence he is likely to remain in conditions of secure care for a considerable period of time.

10. B's mother.

10.1 On 7th August, 2008 B's mother was seen at her home by two members of the Team. She and her partner live in a well maintained terraced home. She was forthright in her views and was most helpful and patient in answering the questions put to her.

10.2 She described her son as entering a pattern of medication reduction, or simply not taking it, a cycle of him being reasonably well when compliant and on reasonable doses of medication and then very, very poorly when not, with, "his whole being changing". When unwell he would as she described it, "go on the God trail". He would pray before he could drink a cup of tea. He once told his dentist that he was listening, "to me the mouth of God". He anointed people on the bus. He was followed by his mother to churches of numerous denominations. His mother further noted that there was a shift in his character and that when God entered his thoughts and behaviour she could "see the madness in his eyes" and that he could be quite frightening.

10.3 B's mother described the severe impact which the diagnosis of paranoid schizophrenia had on him when the implications were explained to him by his consultant. B believed he was to get better and was desperate not to admit he was ill and "didn't have much time for professionals visiting and kept a lot behind his back of what was going on". She said that he was good at masking symptoms. A major difficulty with medication was his weight gain which was reported to be some five stone in one year. During this excessive weight gain he was eating approximately 100 bags of crisps a week, chocolate and was obsessed with eating fast foods.

10.4 She described how plagued he was with thoughts of aliens and with one in particular which he firmly believed would eventually get him. He reported aliens being in the home all of the time.

10.5 His mother went on to describe how she felt angry as to how easy it was for her son to abscond from care when in hospital and that when he was at home, or in hospital, she felt she was living on the edge all the time. On one occasion he had absconded from the unit he was in, went home and changed into his best clothes and presented himself to the local central police station where he reported for duty as a plain clothes detective. He was returned to hospital and the next day he was back at her door. On another occasion he was picked up by police as he was walking to the local airport and on another walking to a regional airport, which was some hundred miles from his home, and

was returned with badly blistered feet having only completed part of the journey.

10.6 His mother was asked how she raised her concerns and how these were received and dealt with. She stated that over time she felt like a nuisance relative and felt her son's care team may be getting a little fed up of her. On many occasions she thought that very little was being done for him and she often asked herself, "what are they actually doing?". She had a direct telephone number, which she had obtained, that put her through to the consultant's secretary. The jist of many of these calls was, "please do something for my son, please help my son, he is so ill". She was critical that on admission he could find himself in a numerous range of units with staff who knew little of him and on one occasion he was admitted to a unit a considerable distance from his home.

10.7 Events of the 3rd of November 2004 were discussed with her and her views sought. Clearly she firmly believed that her son should have been detained under the Mental Health Act, 1983 under Section 3, she clearly expected this and was led to believe that this would be so. She also strongly expressed her view that it would have been an appropriate time to review his medication, plan for his future care and treatment and to simply get, "a grip of his symptoms and bring some longer term stability to his life and ours." Decisions made at this time are discussed in the Team's considerations later.

10.8 The events following the homicide of T and as the police investigation progressed eventually led his mother to ask him, "you haven't done that son?" at which he became upset and replied, "how do you think I could do this to anyone?" She went on to describe her son's later arrest at her home by the police and all of the subsequent events which followed.

10.9 These events have been, and continue to be, very difficult for her to live with. She now has to visit her son in a hospital which is many miles distant and she and her partner do not have access to a car and have to rely on the help of others.

10.10 The final hope expressed by B's mother was that she would be reassured by this report that lessons had been learnt.

11. The MH Trust's Internal Investigation, April 2006 and Action Plan

We have described the process adopted earlier in the report. There are some five pages of detailed findings which are distilled into two pages of recommendations. It is important to emphasise that these findings and resulting recommendations were identified by the MH Trust as were their recommendations for action. The Team has viewed these and has abridged the key issues for the reader and present them in italics. Not all areas are noted here as those that were administrative in nature were easily rectified, for example the structure of files and that records follow the patient and are not kept on separate sites. The MH Trust Board considered the internal investigation report, conclusions, appendices and action plan under the private section of the Board's agenda on the 26th April 2006.

11.1 Pattern of admission and leave

11.1.1 There was a consistent pattern of admission of B followed swiftly by a pattern of increasing leave, with returns from leave and the outcome not being consistently recorded in nursing notes. Carers views were not routinely sought during or following periods of leave. B spent a lot of time on leave even though he was documented as being unwell. An urgent need to ensure practitioners fully understood the Leave Policy of the Trust and that the responsibilities were adhered to was identified.

11.1.2 The internal review team found that, *in view of the severity of his illness more weight should have been given to formal admission.*

11.1.3 It was observed and commented on, *the one occasion when his mental state improved and he appeared stable and well was determined by three factors. These were:*

- *He was detained under the Mental Health Act, 1983 - under sections 136, 2 and 3.*
- *He did not proceed quickly on leave.*
- *He had medication consistently and this was able to be monitored.*

11.2 Risk assessment

11.2.1 Admission risk assessments were cursory and failed to examine the chronology of events leading to the admission or the previous history.

11.2.2 There was no record that risk issues were routinely discussed at the inpatient multi-disciplinary team meetings and do not appear to have been fully taken into account.

11.3 ***Treatment***

11.3.1 The MH Trust's own findings and conclusions in this area are most worthy of note as they encapsulate the majority of the core issues pertinent to B's care and treatment.

11.3.2 "*It was apparent that B was difficult to engage in many aspects of treatment. He was reluctant to accept that he was unwell, disliked being in hospital, was poorly compliant with medication and would not fully communicate with any professionals.*

11.3.3 There is a consistent theme of non-compliance with prescribed medication particularly when he was unwell. His suitability for the use of Clozaril was considered and felt to be untenable. A comprehensive substance misuse history was never taken although there continued to be queries if the diagnosis of schizophrenia was drug induced.

11.3.4 A full 'Carers Assessment' should have been undertaken at the outset and reviewed annually. There was no evidence that this took place and it was not clear who should take the responsibility for organizing this".

12. Action Plan as at September 2008

The Team was provided with an update by the MH Trust's current Medical Director on progress of the original action plan attached to the internal investigation report of 2006. Details of key areas are as follows.

12.1 ***Leave and Section 17 leave.***

12.1.1 This action area has been broken down into various elements and these addressed the need to ensure that practitioners fully understood the leave policy; undertake regular review of the Section 17 leave documentation and appropriate recording within patient records; provision of good practice notes where leave is sanctioned outside of the regular multi-disciplinary team meetings; documenting commencement and return from leave within nursing notes and a review of outcome from leave, clearly documented and taken into consideration when considering extending or granting additional leave.

12.1.2 There is evidence these have been enacted and guidance notes developed where required, and audits completed for consistency with good outcomes.

12.2 Drug Screening

12.2.1 A protocol for routine drug screening has been developed for use in the admission process where patients are suspected of using non prescribed substances. This has been underpinned with policy and guidance and following practical experience is currently undergoing review. A refusal to provide a specimen for drug screening is now clearly documented in the patient record with the patient monitored more vigilantly.

12.3 Risk Assessments

12.3.1 It was identified that risk assessments should take account of previous history and should examine chronology of events and that a comprehensive risk assessment should be completed on each admission and used to inform care plans and in particular periods of leave. The risk assessment tool currently used is in the process of replacement.

12.3.2 The recommendation dealing with record keeping states that an audit of the implementation of the risk assessment policy has been completed, with reported improvement.

12.4 Carers Assessments

12.4.1 These now must be offered routinely as outlined within the Care Programme Approach Policy and that Care Coordinators must be reminded of their obligation to offer a comprehensive 'carers assessment' of need irrespective of their professional background. This responsibility does not solely rest in the domain of the social worker. The uptake of such assessments are part of standard performance monitoring. It is recognized that there is an emphasis on carers contained within the New Care Programme Approach (October 2008) and assessment packages have been made available.

12.5 Record Keeping

12.5.1 The need for an urgent review of the structure of the integrated record to be undertaken was identified to enable clinicians/practitioners to gain essential and contemporaneous information with ease and that a filing protocol was developed to ensure that patient information is filed to a given standard. A regular system of audit is practiced and of importance a chronology of significant events proforma has been produced and how these key items are transferred from a previous volume of notes to the current one without loss of this key information. Considering the importance of this there has been significant improvement reported.

*12.6 **Development in services since incident***

12.6.1 The MH Trust currently provides specialist mental health, learning disability and addictions services to a population approaching 600,000 with an annual turnover of some £80m. The Annual Plan is shaped by a new strategic direction for the MH Trust as it moves to Foundation Trust status. During 2007/08 the MH Trust acquired, in effect, a new Trust Board with the appointment of a new Chairman, Chief Executive and Non-Executive Directors. A new post of Director of Human Resources and Diversity has been developed to take forward a workforce strategy.

12.6.2 In 2007/08 the MH Trust achieved implementation of the major 'whole system model' service redesign within budget and timescale, resulting in improved adult mental health services with a single point of entry and initial assessment.

12.6.3 The MH Trust has identified a range of intentions and priorities in the 2008/09 annual plan and the work of the new Director described above in bringing together relevant staff from Personnel, Corporate Training, Clinical and Medical Development Departments should auger well in the cohesion of staff development, training and appraisal and if linked to the audit system should address any residual systemic needs identified in the case of B and those allied to clinical practice, staff appraisal and continuing professional development issues identified at that time.

*12.7 **The Health Care Commission Report for 2006/2007***

12.7.1 The Health Care Commission Report for 2006/2007 reports on all of the 69 NHS trusts that provided mental health acute inpatient services over this period of time. Each was allocated scores against certain

assessable criteria. The Key used is 1, Weak; 2, Fair; 3, Good and 4, Excellent. The MH Trust scored 3, Good.

12.7.2 In 2007/2008 the Trust scored 4, Excellent. For both periods the MH Trust scored 3, Good, for its use of resources.

12.7.3 In total all trusts registered some 550 acute mental health wards within the scope of the review providing some 10,000 beds. Each trust was scored based on the aggregation of results from 58 indicators.

12.7.4 General key findings (not specifically relating to the MH Trust) noted that almost two thirds of trusts (39%) were scored weak on involving service users and carers – this was the highest proportion of weak scores (the MH Trust scored 2, Fair, in this section). The Commission therefore noted that approaches to involving carers need to be developed further. Nearly a third of trusts case records (30%) did not record whether or not the service user had a carer. Only 32% of front line staff had been trained in supporting carers and families, and only two fifths (40%) of wards had a dedicated member of staff responsible for leading on carer issues. One in five wards (21%) did not have an information pack for carers.

12.7.5 Of particular note specifically relating to the MH Trust was the score of 4, Excellent, for the clinical supervision and ward manager leadership development. This was commented on it the section relating to our visit to the inpatient services.

13. Services Visited

13.1 .The Team could no longer see all of the units on which B had received inpatient care as service re-configuration had changed their use and number. At the time of B's care the Trust acknowledged that he had been admitted to a wide range of facilities.

13.2 We visited the unit he had received much of his care on. This is situated within a community setting, was purpose built and was well maintained. As part of the complex a Community Mental Health Team (CMHT) had been located there. However this team had been recently relocated some distance away. This was viewed as a wrong move for the unit. On our visit there were two male patients who were very disturbed, hostile and very threatening. They seemed to be wrongly located. There did not appear to be the level of staffing available to safely confront the behaviours being displayed. Previously we were told that CMHT staff were called upon to help deal with such behaviour. We mention this as it confirms B's comments on

being afraid in the unit. On occasion staff have to resort to police assistance to deal with destructive behaviour with, we were told on one occasion, a fixed penalty notice being served on the patient. This unit now receives patients requiring longer term treatment following a seven day assessment of their needs at the newly developed single point of entry to services.

13.3 A specific recommendation is made concerning staffing levels and safety for staff and patients on this unit.

13.4 We visited the single point of entry site which is adjacent to the Psychiatric Intensive Care Unit (PICU). This initial assessment unit had good facility for nursing disturbed patients and the PICU had been refurbished and extended.

13.5 In discussion with staff it appeared that historically the PICU had lacked a consultant to take direct charge of it. Eventually this function was taken up by a forensically trained consultant and managed by the clinical director and consultant forensic psychiatrist from within the MH Trust's forensic service. There appeared to be a view that this aspect of the service did not serve the needs of the adult mental health services and that historically there had been difficulties in referring patients into the service and then taking them back. We were informed by staff there appeared to be a point when some of the consultant group did not refer to this facility. There was a clearly held view that the PICU should be managed within the adult services. We discussed these general observations with the clinical director concerned and agreed that we would recommend monitoring and auditing of the use of this service, which if the overall direction the service is now embarked on is to work then this is a vital link which should be sensibly utilised. There is a clear need for the detention and treatment of patient's requiring such facilities and that there movement from other parts of the adult service provision are easier to facilitate.

13.6 Within this same unit are located the key service of Crisis Resolution which is being developed to underpin the MH Trust's new strategic direction. There appeared to be a vibrant group of staff developing these. Their new ways of working were paying dividends by way of contributing to the reductions in inpatient bed usage and they were now dealing with increasing numbers of referrals. This part of the service is currently being monitored.

13.7 The senior nurse unit managers we met were impressive and reassured the Team that the service was managed by capable individuals on a daily basis.

14. Interviews with staff of the MH Trust.

The Team interviewed the MH Trust's Medical Director, B's consultant psychiatrist, B's CPN prior to the offence, the local authority Approved Social Worker (ASW) operating at the admission of November 2004 and the MH Trust's Risk Manager.

14.1 The Medical Director

14.1.1 The Medical Director presented a clear account of the changes to the practice and development of the consultant group now operating MH Trust wide. He became the Medical Director in January 2006 and took up his new duties in the summer of that year. As Medical Director he has no operational responsibility for the daily running of the service as that clearly falls to others. He is responsible for the professional lead of the medical staff and their input to adult mental health services. He is also the lead for all other specialties in psychiatry and the Head Quarters functions of Clinical Governance, Risk Management and Pharmacy. Prior to appointment he had practiced as a consultant psychiatrist. He now practices clinically one day per week.

14.1.2 The clear message was that when the review of consultants' workloads was commenced in 2004, leading to the current 'New Ways of Working' strategy, that they were not sustainable. The consultant group devised the principles and working practices to be adopted and these were modified during the gestation of the strategy which operated as the new model from June 2007.

14.1.3 The Team was interested to hear how mentorship, appraisal and continuing professional development operated. We were informed that mentorship met with the regional scheme requirements and that where supervision was also a requirement then that was permanent and substantive and was provided by consultants trained in such activity via a pool model. The entire consultant group is subjected to a '360 degree' clinical appraisal every three years. Governance systems have tightened up and caseload management is monitored. Operational issues relating to job plans are agreed within the MH Trust's new 'Business Units'.

14.1.4 The Medical Director was asked what areas he felt needed more focus in order to further develop the service.

14.1.5 These were:

- A single site unit for adult mental health services.

- Production of the Medical Strategy required by the newly appointed Director of Human Resources and Diversity.
- A substantive group of Consultant Psychiatrists as opposed to locum appointments.
- A meaningful and practical model of Clinical Risk Assessment for use by all clinical practitioners (now in practice throughout the MHTrust).
- Greater clarity of the status and contribution which can be given to patients care and treatment by relatives and carers.

14.2 B's Community Psychiatric Nurse

14.2.1 The CPN qualified in 1991 and was an experienced nurse.

14.2.2 He became involved with B in 2002 when the previous CPN had left. He confirmed the devastating effect the diagnosis of Paranoid Schizophrenia had had on B and that B had convinced himself, through his own research via the internet, that he had a Borderline Personality Disorder. He found that B masked his symptoms and was guarded and was always keen for the CPN not to discuss his case with his mother. This obviously placed the CPN in a difficult position as to how this could be dealt with on a longer term basis.

14.2.3 B would engineer it so that he received his injection at a time when his mother was at work and would then quickly usher the CPN out of his home. This strategy employed by B did not work as well as he probably hoped as his mother, who clearly witnessed his struggle with his deteriorating mental health, at times pressed the alarm button and alerted services.

14.2.4 The events prior to the homicide by B and the steps the CPN took to ensure B had his required medication at that time reflect well on his persistence in carrying out his initial duty to ensure B received his depot injection on time and consistently. He reported changes in symptoms to those who needed to know and responded quickly to concerns raised.

14.2.5 Since the event the CPN has carried the burden of what could he have done differently to have helped prevent such a tragic occurrence? We thought it correct to enquire into the caseload he had at the time and what was very clear was that B did not present as difficult to manage compared with many of his patients, some of which he knew to carry knives on a regular basis. We were told that the consultant had referred B to the Crisis Resolution Service for a view

which indicated that he did not meet the criteria for their service and would not have been seen as a priority.

14.2.6 He informed us that B had argued with his mother the night before and that the argument had not been satisfactorily resolved. On his return home the next day, having committed the offence, he had told his mother, "everything will be alright now".

14.2.7 We found on close examination that the CPN clearly carried out his duties at that time as diligently as he could within the context of his work and his actions contributed in no way to the events which occurred on the 5th of January 2005.

*14.3 **B's Consultant Psychiatrist***

14.3.1 B's consultant psychiatrist has worked as a locum since 1999 in the Community Mental Health Team delivering services to the area in which B was living. The area has a high psychiatric morbidity due to incidence of severe mental illness, socio-economic deprivation, substance abuse and dual diagnosis. He dealt with a high number of admissions to numerous locations with his patients spread over five sites. His medical support was provided by a GP trainee who was new to psychiatry and a Staff Grade Doctor. He described his weekly commitments which drew a picture of a very busy and demanding timetable.

14.3.2 The Team heard his analysis of B's care, treatment and its suitability. He was managed under the auspices of the enhanced Care Programme Approach, had regular contact with service and regular monitoring in outpatient clinics. B was always encouraged in order to prevent his disengagement with the services and with regular reviews of medication in order to determine a balanced approach to ensure his compliance with a medication regime which would be required long term.

14.3.3 The consultant psychiatrist now works as a locum in the newly formed Assessment Team and prior to taking up this new post he spent some six months ensuring the redistribution or closure of approximately some 500 patients he had as his workload.

14.3.4 As has been noted previously the Team had been provided with a detailed analysis and commentary of the entire clinical notes and decisions made over the length of time B was treated. We explored the decisions made and the practice flowing from these. The omissions identified in the internal investigation report have been accepted and need no further illumination here. We were however

shocked to learn of the volume of patients he had involvement with and the amount of domiciliary visits he made in order to respond to relatives and other professionals concerns.

14.3.5 The Team found the consultant to be caring, conscientious, and in the context of the numbers of patients he had, resilient in his endeavours. He, like the CPN, could not have predicted the actions of B on the 5th of January 2005. He clearly had no indication from B when he saw him on the afternoon of the 5th in his clinic with the CPN and B's mother that he had committed such a devastating act.

14.4 The Approved Social Worker (ASW)

14.4.1 We were supplied with the notes held by the local authority relating to their involvement with B. In May 2003 a request was made for an ASW assessment to make an application under Section 3 of the Mental Health Act 1983. The completed form entitled 'Community Care Assessment' gave an indication of the factors taken into consideration in the resulting application being made by the ASW at that time. The assessment identified that no social care service was required at that stage.

14.4.2 The second referral for an ASW assessment in order to make an application once again for B's detention under Section 3 was received on the 3rd of November 2004. There were two required medical recommendations in place. The ASW had in effect 14 days in which to make the application.

14.4.3 We were told that when visited at his home B managed to contain his symptoms for some twenty minutes and the outcome of when they emerged has been described earlier. What the Team wished to determine with the ASW was if, apart from making his assessment in order to make an application for B's detention, he had been given a brief as to the clinical teams plan should he be detained. Detention in the first instance would give the multi-disciplinary team a period of up to six months to treat him. As noted in the internal investigation B's mental state had improved when detained in 2003 and that the internal investigation team added that due to the severity of his illness more weight should have been given to formal admission.

14.4.4 There was no such indication of a treatment plan following detention available to the ASW although he acknowledged that he was able to discuss individual cases with the doctors. In this case the ASW following his assessment of B did not judge it necessary to follow this option.

14.4.5 We next moved to the issue of the nature and degree of B's mental illness. The degree of his illness was apparent by his presentation on initially being seen by the ASW (who had not met B or had any knowledge of him previously, although he was one of the most floridly psychotic people he had ever seen). The nature of his illness was less apparent although this could have been determined through conversation with staff in the unit who knew B and by reading his clinical notes. At the time (2004) he was unable to access the MH Trust's and local authority central records out of hours, with the written records being held elsewhere.

14.4.6 The decision not to make the application is the ASW's and the ASW's alone. It is an onerous and difficult responsibility to discharge. The consultant has a large influence in this process particularly if there is an issue of nature rather than degree.

14.4.7 The ASW had two medical recommendations and knew the wishes of B's mother in this matter, had interviewed the patient and decided not to make the application for B's detention.

The actions taken in not detaining B in November 2004 were considered at length by the Team. Of course what is now known gives an unfair retrospective opportunity to comment on what if the application had been made and detention commenced? Would that action have ensured B's longer term detention in hospital with the possibility of the unfolding events taking a different course? What in effect happened is that the historical pattern of his treatment was played out yet again. If we are allowed to indulge in one piece of viewing this investigation through a 'retrospective-scope' we would conclude this was a missed opportunity to possibly break into the cycle.

14.4.8 However, given the information to hand and B's presentation when being interviewed in the ward setting in a settled manner, that he indicated he would stay and that he was clearly told by the ASW that if he should abscond again he would reconsider his decision, the action taken could be interpreted by some as reasonable in all the circumstances. The ASW also has the duty to consider the least restrictive alternatives to compulsory detention in order to enable treatment to be received.

14.4.9 However, having considered what we were told and drawing upon our combined experience we found the decision not to make the application questionable in all the circumstances.

14.4.10 B's mother was not informed of her right to make the application as her son's nearest relative within the meaning of the Act.

14.4.11 We were told by the Medical Director when we asked if interventions with such cases were now more rigorous and if the systems could now be more assertive he responded that there is now more attention paid to the looking back on the longitudinal history of the patient and an identification of the risks presented at different points of the patients psychiatric career.

14.4.12 The above assessment process was guided by the Code of Practice for the Mental Health Act which was last revised in 1999. Through the Mental Health Act, 2007, the Government has updated the 1983 Act and issued a new Code. This is significantly expanded in giving comprehensive guidance to mental health professionals. Chapter 4 details at length the considerations now to be taken into account when making application for detention in hospital.

14.5 ***Risk Manager***

14.5.1 Finally we heard from the MH Trust's Risk Manager. We were impressed and reassured with what we learnt of the work now being taken in the area of organizational risk. The Governance arrangements appear robust with a series of weekly, monthly and quarterly meetings. The weekly Organisational Risk Management Committee is concerned with operational risk management and is attended by the Director of Operations, the Medical Director, the Modern Matrons, PALS, the manager dealing with complaints and representatives of the three Business Units. The Risk Register is discussed at the meeting. The monthly meeting of the Safer Services Committee has wider representation, includes the forensic services and considers completed reports and learning the lessons and includes identifying areas for improvement for improvement or development. The quarterly meeting ensures that the loops are closed and that the service is informed of the lessons learnt and audit proposals are considered. A newsletter is the chosen medium to notify staff.

14.5.2 The MH Trust Board receives a monthly report on any Serious and Untoward Incidents (SUIs) and a quarterly report on complaints, PALS issues and claims. The majority of the above action is reactive. Proactively the MH Trust considers national guidance and directives, for example, NICE Guidelines, considers the impact on policy and the Risk Manager attends meetings with the Strategic Health Authority. Compliance is monitored through a network of auditing arrangements

supported by three audit coordinators. The 'Patient Experience' is monitored through the use of patient satisfaction questionnaires. We were told that robust action is taken on issues arising requiring such attention.

14.5.3 We had asked to see the structure of the Case File Documentation and Record Keeping Audit. This was constructed and completed in 2005. The structure and content was thorough and exhaustive and can form part of an iterative process in auditing case files.

15. Risk Assessment

The following addresses the Terms of Reference specifically considering the adequacy of the risk assessment and care plan and how the resulting care and treatment corresponded with statutory obligations and relevant guidance from the Department of Health.

15.1 ***'Rethinking risk to others in mental health services' (March 2008).***

15.1.1 At the outset of the external investigation the Team indicated that they would refer to the above Report of the Royal College of Psychiatrists.

15.1.2 The areas we feel required noting are the following:

15.1.3 "*All psychiatrists are conscious of the immeasurable impact of homicides and violence on victims, perpetrators and families and recognize their responsibility to their patients and the wider public to use their professional skills to reduce risk".*

15.1.4 Key findings of the Royal College's Report note that, *"risk management is a core function of all medical practitioners and that some negative outcomes can be avoided or reduced by sensible contingency planning. Risk, however, cannot be eliminated and accurate prediction is never possible for individual patients. The risks posed by those with mental disorders are much less susceptible to prediction because of the multiplicity of, and complex interrelation of, factors underlying a person's behaviour*".

15.1.5 The limitations and value of risk assessment instruments must be understood. Risk assessment should be seen as an assessment of a current situation, not as a predictor of a particular event. Its critical function is to stratify people into a group (low, medium or high risk),

15.1.6 Improvements are needed in the existing arrangements for training and continuing professional development in risk assessment and management. Core competencies should be identified for psychiatric training.

15.1.7 Cooperation with patients and carers in assessing and managing risk should be fostered through care planning.

15.1.8 The Department of Health, (2007) issued, 'Best Practice in Managing Risk' highlighting some general principles of risk assessment. These are:

- Accurate risk prediction is never possible at an individual level. Nevertheless the use of structured risk assessment when systematically applied by a clinical team within a tiered approach to risk assessment can enhance clinical judgement. This will contribute to effective and safe service delivery.

- Risk assessment is a vital element in the process of clinical assessment. It enables psychiatrists to reach a reasoned judgement on the level and type of risk factors for violence in an individual case.

- Risk assessment informs risk management and there should be a direct follow through from assessment to management.

- The best quality of care can be provided only if there are established links between the needs assessments of service users and risk assessment.

- Positive risk assessment is part of a carefully constructed plan and is a required competence for all mental health practitioners.

- Risk management must recognize and promote the patient's strengths and should support recovery.

- Risk management requires an organizational strategy as well as competent efforts by individual practitioners.

15.1.9 In 2007 the Trust undertook a pilot to consider the use of the 'Galatean Risk Screening Tool' (GRiST) by the adult mental health services. This online decision support system for mental health professionals has been developed by the Universities of Warwick and Aston the development of which was funded by the Department of Health. The tool was recommended within the document mentioned above.

15.1.10 Following the pilot the Trust's Governance Committee endorsed and adopted the GRiST model throughout the adult mental health service in 2008.

16. Relatives and Carers

We do not intend to spell out all of the rights of relatives and carers to be involved in the decisions in planning the mental health treatment of those they care for, love and support. Much of the process of involvement can be based on mutual interest and concern, respect and a willingness to communicate with each other. A listening multi-disciplinary care team can determine not only the needs of the patient but those who are likely, over time, to spend more time with the patient in a non clinical environment. A reasonable carer who is fully integrated and informed of what helps and is very clearly told what to do if situations deteriorate can be an asset.

16.1 ***'Refocusing the Care Programme Approach – Policy and Positive Guidance', Department of Health, March 2008.***

16.1.1 We considered this document, which is to be implemented from October 2008, and set this against what it states concerning the involvement of relatives and carers. We did the same for the revised Code of Practice. As a background we describe some of the guidance issued by the Department of Health.

16.2 ***The Care Programme Approach (CPA)***

16.2.1 This was introduced in 1990 as a framework of care for people with mental health needs and was at that time to run in parallel with the local authority Care Management system. The CPA was revised and integrated with Care Management in 1999 to be used by health and social care staff in all settings, including inpatient care. Two tiers of CPA were established: standard and enhanced. Standard was

described as being for those people whose needs could be met by one agency or professional. People on enhanced CPA had multiple needs which are more likely to be met by inter-agency coordination and cooperation. There is likely to be a higher element of risk and disengagement form services. (B was a patient on Enhanced CPA).

16.2.2 The key elements of this approach were the systematic assessment of individuals' health and social care needs. A Care Plan was to be developed to address those needs. A Care Coordinator was to be appointed and regular review was to take place making changes to the plan to reflect changing need. Close working relationships between health and social services were stressed, as was the need to involve the service user and their carers.

16.3 'The National Services Framework for Mental Health: Modern Standards and Service Models' Department of Health Sept 1999.

16.3.1 The rationale behind this guidance is that, "carers play a vital role in helping to look after service users of mental health services, particularly those with severe mental illness. Providing help, advice and service to carers can be one of the best ways of helping people with mental health problems. While caring can be rewarding, the strains and responsibilities of caring can also have an impact on carers' own mental and physical health. These needs must be addressed."

Standard 6 states that:

- "All individuals who provide regular and substantial care for a person on CPA should:

- Have an assessment of their caring, physical and mental health needs, repeated at least on an annual basis.
- Have their own written care plan, which is given to them and implemented in discussion with them".

16.3.2 We have commented on this as B's mother was not approached and offered this service of a 'Carers Assessment'. This was recognised in the internal investigation report and has been acted upon.

16.4 The Code of Practice

16.4.1 Section 2 of the Code deals at paragraphs 2.39 – 2.42 with the involvement of carers.

2.40 - states that, "unless there are reasons to the contrary patients should be encouraged to agree to their carers being involved in decisions under the Act and to them being kept informed. If patients lack capacity to consent to this it may be appropriate to involve and inform carers if it is in the patient's best interest"

2.41 – notes that, "in order that carers can, where appropriate, participate fully in decision making, it is important they have access to:

- Practical and emotional help to support them to participate; and
- Timely access to comprehensive, up-to-date and accurate information".

2.42 – further states that "even if carers cannot be given the detailed information about the patient's case, where appropriate they should be offered general information, which may help them understand the nature of mental disorder, the way it is treated, and the operation of the Act.

19.4.2 The Team believes by quoting the above there is a clear indication given on the requirement to consider the needs and contribution of carers in the support and care of people with mental health problems. In the case of B's mother her needs were not assessed.

17. Causes and Findings

17.1 The care and treatment of people with mental health needs were in 2005 primarily directed and met by the medical profession supported by other professional groups. As this is likely to remain at this clinical level, in particular for inpatient treatment, then there are great responsibilities to be executed by them. Leadership based on knowledge, not just of clinical practice, but of determining care pathways by the CPA, analysing and describing risk, directing the work of others, involving service users and their carers and relatives at such points as diagnosis and resulting future implications, discharge, compiling plans and modifying them within a dynamically changing situation within often changing community settings. These roles and functions are executed in helping manage the most complex, challenging and highest risk cases. This range of tasks, underpinned

by clinical judgment and risk assessment, will need to form the cornerstone of the MH Trust's workforce strategy

17.2 The following observations need to be placed in context of workloads of the professionals delivering care and treatment throughout the services given in this pressurised Mental Health Teaching NHS Trust. These were commented on when describing meetings with the MH Trust's staff. The service in 2008 is very different and on examination much improved to what it was in 2005.

17.3 There are aspects of B's care which should be highlighted, rather than to just to offer an intense focus on those aspects of his management which can draw criticism.

Notable aspects were:

- Those responsible for his mental health care did respond when alerted to his deterioration when living at home and on balance took action to alleviate his and his carer's immediate distress by rapid home visits and urgent outpatient review.
- Consistent outpatient support was offered and delivered, as was the domiciliary visiting to administer medication.
- B's mother was invited and attended inpatient care planning meetings and outpatient appointments.
- It was very difficult to obtain a full picture from B of what his symptoms were and how they affected him. He was skilled at masking and hiding them from staff and said what he thought they needed to hear in order to simply be left alone. As an inpatient he kept himself as anonymous as he could. He was therefore genuinely difficult to engage.

18. Root Cause and Contributory Factors

18.1 **Having considered all of the above aspects covered in the report we determined the root cause contributing to B's continuing severe mental disorder was that of 'under treatment'. B's situation and condition could and should have been more assertively managed.**

18.2 The main contributory factors were these:

- An over reliance on the debate of his disengagement from services and the levels of intervention in his overall care and treatment,

leading to B dictating, in part, elements of his treatment which should have fallen within the auspices of professional practice.

- Of the six admissions he had over the four year period only one, which was of a prolonged duration and he had been compulsorily detained, had a more noticeable effect on his mental state.
- There was little attention paid to the testing for the presence of illicit drugs. There was no thorough history of his drug use taken.
- He too rapidly proceeded to leave when an inpatient.
- He was able to abscond and absent himself from inpatient care too easily.
- He had little to occupy him through the day in a structured programme when at home.
- Alternatives to living at home were not considered or pursued with any vigour.
- The needs of B's mother and how her relationship with her son and how tensions between them could be helped were not assessed and considered early enough.
- There was no thorough social history taken of his life. This was only undertaken when he was admitted to the High Security Psychiatric Hospital.
- The admission in November 2004 was on the balance of probability a missed opportunity to compulsorily detain B and consider alternative medication and monitor its efficacy in a controlled environment. This was an opportunity for a more proactive response in managing his treatment.
- Previous admissions had little clear purpose apart from that of a reactive response to his mental state presentation.
- The Risk Assessment documentation available at the time was not used to its full potential.

19. Recommendations.

The MH Trust's Board has wide ranging responsibilities to monitor the governance processes to ensure the quality of services provided to those people who require mental health services and meet contractual requirements. We found the recent service directions set by the NHS Teaching PCT and embraced by the MH Trust to be well thought through and although challenging are achieving positive outcomes. The recommendations made below are additional to those developed following the internal investigation's action plan.

19.1 The MH Trust should produce and widely publish the strategy for medical services required by the newly appointed Director of Human Resources and Diversity. It should describe how it intends to aid

locum consultants develop into substantive consultant positions. It should inform readers how clinical governance, continuing professional development, appraisal, supervision, recruitment and retention will improve the patient experience through the services provided by this group. Continuing professional development should include regular updates on risk assessment and management.

19.2 The MH Trust should review and develop information sharing protocols with organisations involved in the care and treatment of mental health patients and should have inter-agency management protocols in place for information sharing about potential risks.

19.3 The newly adopted GRiST risk assessment tool should be subject to rigorous audit and its outcome reported to the Board. Tick box mentality should be avoided and the audit should focus on the quality of the clinical input, observations and interpretation, contingency plans and the flexibility of the process and that the format in use are validated for each specific patient group.

19.4 There should be production of information packs for service users and their relatives and carers concerning areas identified in the revised Mental Health Act Code of Practice and the Care Programme Approach. The documentation should reflect all rights and responsibilities afforded to them.

19.5 The assessment of carers and the progress the MH Trust makes in this area should form an annual report to the Board on the impact future engagement and assessment of need has. The progress should be measured against the existing action plan already developed by the MH Trust with the format of the report being reflected in the action plan to address this recommendation.

19.6 There should be a multidisciplinary peer review system developed, with the emphasis on a learning dialogue, when applications are not made by the Approved Mental Health Practitioner (AMHP – formerly ASW) for detention when in receipt of medical recommendations. Such reviews should be held by a senior mental health practitioner manager from the local authority and actions measured against the new Code of Practice.

19.7 The MH Trust with the PCT now has well developed community based services such as the Assertive Outreach, Crisis Resolution and Home Treatment Teams and has developed the single point of entry system to services. We recommend that the same rigorous planning approach by the PCT and the MH Trust is now focused on the

inpatient facilities to examine their role and function within a changing service.

19.8 There should be a review of the staffing levels available at the unit visited by the Team which now manages without the support of the CMHT staff once located within the building. The MH Trust Board should assure itself that this facility is a safe environment for both patients and staff (and may wish to examine other satellite facilities). It should also ensure that the opportunities for patients to abscond from the unit are lessened.

19.9 The MHTrust Board initially should receive a six monthly report on the referrals to and use of the PICU unit. The report should include any operational difficulties concerning referral and how they have been resolved.