Independent Investigation into the Care and Management of Mental Health Service User 2006/1787

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This independent investigation was commissioned by Yorkshire and the Humber Strategic Health Authority in keeping with the statutory requirement detailed in the Department of Health guidance “Independent Investigation of Adverse Events in Mental Health Services” issued in June 2005.
This requires an independent investigation of the care and services offered to mental health service users involved in incidents of homicide where they have had contact with mental health services in the six months prior to the incident, and replaces the paragraphs in “HSG (94)27” which previously gave guidance on the conduct of such enquiries.

The Investigation Team members were:

- Ms Maria Dineen, Director, Consequence UK Ltd
- Dr Maureen Devlin, Independent Healthcare Consultant and Associate Consequence UK Ltd
- Mr Mike Foster, Assistant Director of Nursing Oxfordshire and Buckinghamshire Mental Healthcare NHS Trust

In addition to the core investigation team advice and opinion was sought from a range of senior mental health professionals and consultant psychiatrists working in crisis and home treatment services about the value and use of third party information in the risk assessment process.

Acknowledgements:
The Investigation Team wish to thank all of the staff at Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust who gave willingly of their time to assist us in understanding the full context of the care and management of the mental health service user involved in the homicide on 2 April 2006.

The Investigation Team also extend their thanks to the sister of the deceased for her openness and candour.

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EXECUTIVE SUMMARY

Intention

This report sets out the findings of the independent Investigation Team following its analysis of the care and treatment of a mental health service user (MHSU) who was convicted of murdering his wife on 2 April 2006. He was subsequently convicted on 9 August 2007 and sentenced to life imprisonment.

Purpose

The purpose of the work commissioned was:

- To undertake a detailed and analytical assessment of the clinical records of the MHSU.

- To critically analyse the documented care provided by Doncaster and South Humber NHS Trust and to identify any areas that appeared weak or unsatisfactory, and to analyse the Trust's internal investigation report in order to identify any significant omissions in the Trust's own investigative process.

- To make recommendations to remedy any practice or systems weaknesses identified during the course of the investigation.

Outline of the review process

The analysis of the MHSU's clinical records and the Trust's own internal investigation report revealed that a reasonable investigation had been undertaken, and that most of the questions the Investigation Team had were addressed. This process enabled the scope of the independent review to be focused on three main issues:

- How third party information is managed by clinical teams.
- What difference would it have made to staff actions and decisions had they been aware that there had been domestic violence towards the MHSU's wife?
- Was the decision of the crisis and home treatment team not to attend at the home of the MHSU's wife reasonable?

The primary activities conducted to answer these questions were:

- documentation review;
- interviews and round-the-table meetings with staff involved in the care and treatment of the MHSU and their local and senior managers; and
- liaison with the family of the victim

Main conclusions

As a result of this review the main conclusions are:

- The care and treatment of the MHSU was of a good standard.
- The wife of the MHSU was appropriately referred to the Carer Support Service. Furthermore this service positively engaged with her and there is clear evidence that she did have the opportunity to share with the Carer Support Service any concerns about her home situation.
- On the basis of the information provided to the mental health services in Rotherham they could not have anticipated the attack by the MHSU on his wife, nor the ferocity of it. Indeed there appears to have been no different course of action the mental health services could have taken that would have protected the MHSU's wife from the fatal attack on 2 April 2006.

Actions taken since the incident

The action plan of 17 October 2006 identified that the Nursing Director would review the recording of information about patients and use of associated tools by March 2007. A review of all the Care Programme Approach (CPA) documentation was undertaken and the Sainsbury Risk Assessment tool was subsequently chosen to underpin the screening risk assessment and full risk assessment components of the CPA approach across all of the Trust's services. This approach also underpinned the commissioning of risk management training and the development of electronic record keeping systems within the Trust.

Recommendations

Although the Investigation Team does not believe this particular incident to have been preventable, it has a number of recommendations for Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust. In summary, these are that:

- How the Trust treats third party information, especially where it relates to the potential for risk behaviour in a service user, needs to be debated within the Trust's governance and risk management groups. It is not acceptable for staff to be expected to use their individual judgment on such an important and sensitive issue.
- The Trust must introduce a section on safeguarding children and adults, to include domestic violence (emotional, verbal and physical) as part of the standardised screening and full risk assessment paperwork.
- The Trust needs to develop a more proactive approach to the education of its service users about excessive drinking, and provide information about local support groups, if the service user and/or family members and carers are concerned about the service user's alcohol intake.

- As part of the Trust's ongoing commitment to improving its approach to and standard of client focused risk assessments, it needs to commit to a regular audit of risk assessment documentation that assesses the quality and clinical usefulness of what has been documented.

- The Trust must produce a detailed project plan, with realistic timescales attached to it, for the strategic health authority (SHA) and primary care trust (PCT) in relation to its intention to:
    - Undertake a contemporary review of its risk assessment and CPA paperwork to assess its compliance with current national standards and best practice guidance.
    - Implement a common risk assessment process across all of its services.
    - Explore options for more responsive approaches to assessment based on need (including safety), integrated working, communication, effective record keeping and the effective supervision of staff undertaking these assessments.

- The service manager for the Crisis Resolution and Home Treatment Team (CRHT) - who recognises that their current service profile document is out of step with the way the CRHT currently operates – meets his commitment to updating this profile, incorporating the feedback contained in this report, by the end of November 2008.

- The thorny issue of how to manage inter-team referrals where the service user is unaware of the referral needs to be properly debated within the context of good governance. It does not seem to be sufficient that the CRHT simply refuses to accept such referrals.

1.0 BACKGROUND

On the morning of 2 April 2006 a mental health service user (MHSU) in Rotherham viciously attacked his wife, beating her to death. He took his two children to a nearby relative, telling them that there had been an accident, and asked the relative to look after the children. He then returned to the marital home. At some point either before taking the children from the home or on his return the MHSU set fire to his wife's body.

The children now live with their aunt who has parental responsibility for them.

Outline Chronology

On the evening of 9 March 2006 the MHSU was admitted under section 2 of the Mental Health Act to the Psychiatric Intensive Care Unit (PICU) at Rotherham General Hospital. His admission followed his absconding from an open ward earlier that same day.

The precipitating factors to his admission were:

- increasing anxiety;
- paranoia; and
- alcohol misuse.

The primary reason for his admission to PICU was to contain the risk of further attempts to abscond as it was clear from the mental health assessment that the MHSU was not willing to accept treatment.

Over the course of the next three weeks his paranoia and overall mental health improved, and he was discharged from PICU to an open ward on 20 March, and then home on 23 March.

On 29 March the MHSU was reviewed by his consultant psychiatrist in outpatients. At this time there was no evidence of delusional thinking although he did remain 'highly strung and anxious'.

On 31 March the MHSU's wife telephoned the Carer Support Service (CSS). She reported that her husband remained quite paranoid and had taken her mobile phone off her and also her disability living allowance forms, as he believed they were for putting him back in hospital. She also reported that he was accusing her of trying to give him an overdose. She advised the CSS that she felt unable to cope without support. The CSS said that they would advise her husband's consultant psychiatrist of the situation.

A short while later, on the same day, the MHSU's wife again called the CSS and told them that she did not want her husband in hospital. She also told the CSS that she had just felt alone and wished to speak with someone about how to handle the situation. The notes show that further reassurances were provided. She was told that if she did want

further support and/or advice she could get back in touch with the CSS service by phone or she could visit Godstone Road if this was preferable for her given the tensions at home. During this call the MHSU's wife told the CSS that she had the Crisis Resolution and Home Treatment Team's (CRHT) number if she needed support over the weekend.

The MHSU's consultant psychiatrist did ask the CRHT to intervene and has written in the notes "spoken with HTT – they will assess".

Over the following 48hrs the CRHT did make a number of attempts to make contact with the MHSU, using both landline and mobile phone numbers. They were aware that the MHSU's wife did not want a hospital admission for her husband, and that the MHSU had removed her mobile phone from her earlier on the 31 March. They were also aware that she had phoned the CSS to advise that she was OK but had just wanted someone to talk to. They were not aware of the history of domestic violence inflicted by the MHSU on his wife, or the re-emergence of this since Christmas 2005. No one was aware of this.

Instigating a Mental Health Act assessment was considered by the CRHT and then not thought to be appropriate on the basis of the MHSU's wife's recent telephone calls and the content of these. There was nothing to suggest that she was not able to make a call to the CRHT if the situation had worsened. (It is known that the deceased did speak with her family the evening before her death.)

On 1 April the MHSU and his wife were at her mother's home for the afternoon. They recall that he was suspicious and paranoid believing his mother in law was trying to poison him and accusing his wife of the same.

The attack by the MHSU on his wife occurred on the morning of 2 April 2006.

PLEASE SEE APPENDIX 1 (page 31) FOR A MORE DETAILED CHRONOLOGY OF THE MHSU'S CONTACTS WITH THE MENTAL HEALTH SERVICE

2.0 TERMS OF REFERENCE

Before determining the scope of this investigation and thus the terms of reference, Consequence UK was asked to:

- conduct an initial analysis of the MHSU's clinical records,
- determine the questions investigators would want to ask and areas that required exploration,
- assess the adequacy of the internal investigation report and the extent to which it provided a reasonable analysis of the MHSU's care and treatment, and also the extent to which it answered the questions of the independent investigation team.

As a result of these activities three areas meriting further exploration were identified:

- How the mental health service provided by the Rotherham and Doncaster Mental Health Services manages third party information when it pertains directly to a service user in their care.
- Whether or not knowledge about the degree of domestic violence in the home of the MHSU would have prompted different actions by the MHSU's consultant psychiatrist on 31 March 2006, and/or the CRHT between 31 March and 2 April.
- What avenues are available to the CRHT for making contacts with service users and their families when there is concern for the safety or wellbeing of anyone in the home.

The Investigation Team also agreed to clarify with the MHSU's consultant psychiatrist his rationale for discharging him three days after his discharge from the Psychiatric Intensive Care Unit to an open in-patient ward.

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

To report:
The Investigation Team's findings and recommendations to the Board of Yorkshire and the Humber Strategic Health Authority

3.0 METHODOLOGY

This was a targeted investigation of the care and management of the MHSU concentrating on the period between 9 March 2006 and 2 April 2006.

The specific investigation and analysis tools utilised were:

- The *Consequence UK Ltd Structured Timeline*;
- simple gap analysis;
- interviewing; and
- round-the-table discussion (open and structured)

The primary sources of information used to underpin this review were:

- The MHSU's mental health records held by Doncaster and South Humber Healthcare NHS Trust;
- Staff engaged in the care and management of the MHSU;
- Managers of the CRHT; and
- Liaison with the victim's sister.

4.0 CONTACT WITH THE FAMILY OF THE MHSU AND THE FAMILY OF THE VICTIM

At the commencement of the investigation the Investigation Team wrote to the MHSU advising him of the investigation, offering him the opportunity to meet with the Investigation Team and seeking his permission to have access to his medical and police records. The MHSU did not want to meet with the Investigation Team and was not agreeable to our having access to his records.

The Investigation Team did enlist the support of the staff on the lifer unit in the prison in which the MHSU resides to try and persuade him to cooperate. This was unsuccessful.

It was determined with the Yorkshire and Humber Strategic Health Authority that it was in the public interest that access to the records was provided. Furthermore delivering the statutory requirement of HSG(94)27 was not possible without access to these.

The Investigation Team did successfully contact the sister of the victim and following a detailed telephone conversation it was agreed that on completion of the report, a member of the Investigation Team would meet with her and her mother to take them through the report. This meeting occurred on 4 November.

Contact was also made with South Yorkshire Police to find out the contact details of the family of the MHSU. Because the police case file has now been archived, and the family of the MHSU's wife remain in contact with his family, their help was sought to make contact with his sister and mother. Telephone contact was made with the sister of the MHSU on the 3 November. The investigation process was explained to her and an offer made to meet with her and her husband. This offer was not accepted at the time. It was agreed that the MHSU's sister would make telephone contact with Consequence UK if she decided that she did want to meet. With regards to the MHSU's mother, his sister informed Consequence UK that she did not think making contact with her was appropriate and that she would come to a decision about informing her.

Note
The Investigation Team believes it is important to note that the family of the victim do not believe that there is anything anyone could have done to prevent the attack on their sister/daughter. Furthermore they were clear in their assertion that they definitely do not hold the mental health services responsible for what happened.

5.0 FINDINGS OF THE INVESTIGATION

The terms of reference for this investigation required the Investigation Team to:

- Comment on the Trust's own internal investigation
- Find out how third party information is treated when it is directly related to the potential risk profile of a service user.
- Determine what difference it would have made to staff actions and decisions had they been aware of the level of domestic violence directed by the MHSU towards his wife.
- Comment on the appropriateness of the MHSU's discharge home three days after his discharge from the Psychiatric Intensive Care Unit to an acute inpatient ward.
- Determine whether or not it was reasonable for the crisis team to take a cautious approach in making contact with the MHSU between 31 March and 2 April 2006.

This section of the report therefore sets out the Investigation Team's findings in relation to these issues. However before addressing the above the Investigation Team believes it important to note some particular areas of good practice in the service offered to the MHSU and his wife.

5.1 The appropriateness of the MHSU's care and treatment – positive feedback

There were three notable elements of good practice in the service offered to the MHSU and his wife. These were:

- The initial decision by the CHRT team member, who first assessed the MHSU in A&E on the morning of 9 March, to admit the MHSU on an informal basis.

- Following the MHSU's subsequent refusal to stay on Ward C1 (an acute inpatient ward) the decision to assess him at home under the Mental Health Act was appropriate. He was displaying symptoms of paranoia, he had engaged in high risk behaviour in that he was drink driving, he was very suspicious of the mental health care team and his wife believing them to be in collusion, and he had had some thoughts of suicide. The outcome of his assessment was compulsory detention under Section 2 of the Mental Health Act.

- The decision to admit the MHSU directly to the Psychiatric Intensive Care Unit (C3) because of his high risk of absconding represents good practice. Some practitioners may suggest that because the MHSU did not present with any violence or aggression risk, that placing him in a care environment of this

intensity was not necessary. However the purpose of admitting someone under section 2 of the Mental Health Act is to effect a full assessment and to instigate treatment if indicated. If the service user is not present on the ward the mental health service cannot deliver the purpose of a section 2 admission. As independent investigators we have assessed a number of cases over the last five years, where effective assessment of a service user detained on section 2 has not been achieved because the service user has spent more time off a ward than on it.

- The wife of the MHSU was referred to the carer support service on 9 March by the approved social workers (ASW's) who participated in the Mental Health Act assessment. The Carer Support Service (CSS) made contact with the MHSU's wife on 9 March at 09.20hrs. She subsequently had seven further contacts with this service**.** Although the needs of families and carers of mental health service users are much more recognised now than they were a few years ago, it is commendable that the referral of the MHSU's wife was so immediate, and that there was clear evidence of subsequent contacts between the MHSU's wife and the CSS service. We know from our conversation with the MHSU's wife's sister that she found the service provided by the CSS helpful.

5.2 The Investigation Team's findings in relation to the terms of reference

5.2.1 The quality and completeness of the Trust's internal investigation

The Trust provided the Investigation Team with two reports. One that was entitled "Interim Report into Events of Sunday 2 April 2006 Culminating in the Arrest of the *MHSU".* There was also a second report prepared for the Trust Board. The content of the two reports was very similar.

In determining the adequacy of the Trust reports a number of questions were applied by the Investigation Team. These were:

- Were the terms of reference apparent and, if yes, were they reasonable, and have the investigation and investigation report addressed these?

- Have all key facts been identified, as far as can be assessed based on an analysis of the clinical records?

- Have the diagnosis and adequacy of care of the MHSU, including key issues of concern, been appropriately explored? Are there any gaps in the Trust investigation based on the key areas for exploration identified as a result of the case notes review/analysis?

- Have issues such as:
    - risk assessment (including risk management and relapse planning);
    - care planning;
    - Care Programme Approach;
    - clinical supervision;
    - interagency communications;
    - inter-team communications;
    - housing;
    - support for carers/families including carer's assessment;
    - team performance and leadership; and
    - service culture

  been adequately explored?

- Are the conclusions of the report congruent with the facts as elicited from the case notes analysis?

- On the basis of the content of the internal investigation report do the recommendations made appear appropriate? Will they, if implemented, reduce the risk of a) the incident occurring in the future and b) the occurrence of similar care management concerns, if any were identified?

- Did the internal investigation report show that a systems based approach to the investigation was taken, or was the overriding impression one of an investigation predominantly focused on the care and management of the service user with little evidence of a deeper or wider systems analysis?

The following presents the Investigation Team's reflections on the Trust's internal investigation reports. Where the Investigation Team elicited further relevant information from the staff responsible for the care and management of the MHSU, this has been included.

Terms of reference: There were no stated terms of reference in either the preliminary internal investigation report or the report subsequently presented to the Trust Board. For an investigation of this seriousness this is not good practice. Terms of reference should set out clearly what is expected of the internal investigation team, or investigator. All serious incident investigations should have terms of reference which are agreed between the commissioners of the investigation and the investigator and/or investigation team.

Key facts: These were fully presented.

Diagnosis and adequacy of care: All reports identify that the initial diagnosis of a 'brief psychotic episode' was reasonable given the information available to the clinical team at the time and the MHSU's subsequent improvement during his inpatient period. That is, his delusions dissipated over this time. However the report prepared for the

Trust board suggests that because the MHSU's symptoms had been present for some three months prior to admission, coupled with knowledge of the MHSU's behaviours whilst on remand, a diagnosis of delusional disorder (ICD10 code: F22.0) may have been more accurate.

With regards to the risks the MHSU presented, the internal investigation reports note that he had one episode of serious violence and aggression some 17 – 20 years prior to his detention under Section 2 of the Mental Health Act. This was related to a drunken brawl when he was in his late teens and the consequence of this was a three year custodial sentence. In relation to his contemporary risk history the MHSU was noted to have taken his car out after an argument with his wife. On the course of his journey he did drink and eventually turned himself into a police station in Cambridge because he knew he should not have been driving. He was subsequently arrested for 'drink-driving'. These issues were of sufficient concern, coupled with his reluctance to accept the care of the mental health service, to prompt the decision to assess him under the Mental Health Act.

The key area of concern identified within the internal investigation reports was the lack of detailed recording by the first member of the CRHT to assess the MHSU. This individual noted that he had a history of 'violence and aggression' but no context about this was recorded. The internal reports note that it was assumed that this record related to the episode of serious violence and aggression some 17-20 years previously. However the Trust's internal investigation revealed that in fact, it related to third party information shared with the assessing clinician by another unqualified team member, relating to her previous knowledge of domestic violence in the MHSU's home some years previously. A consequence of the inadequate recording was that not one member of the mental health care team, who had contact with the MHSU and his wife in the following 24 days, was at all aware that there had been previous domestic violence. What is not addressed in the internal investigation reports is what, if any, difference such awareness would have made to:

- the way the MHSU was managed; and
- the way in which contact and questioning of the MHSU's wife was conducted.

Please see Section 5.2.3 page 22 for further information

With regard to the medications prescribed to the MHSU, the internal investigation reports do say what medications were prescribed, namely

- Fluoxetine (an anti-depressant) 20mg once a day from 10 March to 13 March 2006
- Amisulpride (an anti-psychotic) 200mg twice a day from 13 March to 16 March 2006.

The fluoxetine had previously been prescribed by the MHSU's GP and was therefore continued during the initial admission period. The amisulpride was commenced following a ward round on the 13 March where it was apparent that the MHSU's paranoid ideas and not depression seemed to be the MHSU's main problem. Although not stated clearly in the internal reports the reason the amisulpride was stopped after three days was that the MHSU was experiencing side effects with this medication and refused to take more of the medication. On discussion with the Consultant Psychiatrist in PICU the Investigation Team understands that no further medication was prescribed as the MHSU was improving. The decision to observe his progress unmedicated was reasonable.

Comment by Investigation Team:
An observation by the Investigation Team was that although the MHSU's contemporary behaviour appears to have been appropriately described, there is little information relating to his pre-morbid personality. A more detailed description of how he was before Christmas 2005 may have been helpful. Whether a more detailed picture of the MHSU's pre-morbid state, and the circumstances leading to his changes in behaviour, would have made any material difference to his subsequent management, or to staff perceptions of his risk profile, is impossible to say.

Both internal reports comment on the moderate intake of alcohol consumed by the MHSU. He was consuming around 4-5 pints of beer a night for about 3 months. This equates to a unitary intake of between 84 and 104 units a week. Although this is significantly higher than the national recommended limit, in itself this quantify of alcohol consumption is not particularly remarkable. The staff that had contact with the MHSUI at the time of his admission on 9 March also advised the Investigation Team that there were no signs of him being intoxicated, and neither were there any signs of alcohol withdrawal when he was admitted to PICU.

With regards to the MHSU's diagnosis neither the consultant psychiatrist on PICU nor the MHSU's nominated consultant psychiatrist agree with the finding of the Trust's internal investigation report that a more appropriate diagnosis was delusional disorder. On the basis of the MHSU's presentation between 9 March and 23 March 2008, and the limited time period that he had been behaving oddly prior to this, they remain of the opinion that a brief psychotic episode remains the correct diagnosis. It is the understanding of the Investigation Team that after a period of assessment in Rampton Hospital following the

homicide, the MHSU was diagnosed with an untreatable personality disorder. In relation to the difference of opinion between the Trust's investigation team and the clinical staff who were responsible for the MHSU, we would have expected this difference of opinion to have been clearly stated within the Trust's investigation report to the Trust Board along with the rationale for the diagnosis of 'brief psychotic disorder' which was perfectly reasonable. For completeness the rationale was:

- The MHSU had not had false beliefs for a prolonged period of time. His presentation was acute in nature.
- The MHSU's beliefs reduced quickly during his period on PICU and by time he was discharged he was articulating that he knew they were wrong beliefs.
- The MHSU's beliefs settled without any active treatment. Although he was prescribed fluoxetine and then amisulpride he did not take these for any length of time so any therapeutic benefit is questionable.

With regards to the risk assessment undertaken with the MHSU, we would have expected evidence of a more inquiring analysis within the internal investigation reports. We accept that it is acknowledged that a fuller risk assessment should have been undertaken, but the reasons why this did not happen are not detailed. The Investigation Team has been able to establish that the main contributory factor to the lack of a more comprehensive risk assessment was the lack of clarity in the systems and processes as to who should undertake this. It was not the expectation that the staff caring for the MHSU on PICU at the time should undertake the more detailed risk assessment. There seems to have been an assumption that the appointed care coordinator would do this. The staff the Investigation Team met with also suggested that there was an element of custom and practice regarding the lack of follow through with a more detailed risk assessment.

Although such an approach to practice is wholly unsatisfactory the Investigation Team have not been able to find any information to suggest that a more in-depth risk assessment would have made any difference to the subsequent course of the MHSU's care and management, or to the staff being able to identify any potential or actual risks to his wife or children. With regards to the risk of domestic violence the information shared by the sister of the deceased is particularly informative. Her recollection is that domestic violence was a constant feature of the MHSU's relationship with her sister. She also recalls that following the birth of their children the relationship between the MHSU and his wife had much improved and there were no overt signs of domestic violence. However, from Christmas 2005 overt signs of physical violence were again present in the form of facial bruises and other marks on her sister. The sister of the deceased also told the Investigation Team that her sister would not have divulged any information suggestive of domestic violence to the mental health services. Both she (the sister of the deceased) and her mother had on a number of occasions urged her sister to leave the MHSU. The most

recent attempt was when he was admitted under Section 2 of the Mental Health Act. The sister of the deceased told the Investigation Team that her sister would not do this because she loved her husband.

Staying with the theme of risk assessment, the Investigation Team were unimpressed by the quality of contextual information recorded around the identified risk behaviours of the MHSU. This is commented on in the internal investigation reports but there is no evidence of exploration as to why contextual information around all identified risks was not recorded. The inadequacy particularly relates to the records of the social worker (SW1) who initially assessed the MHSU in A&E on 9 March. On return to the CRHT office it appears that SW1 was advised by a non-qualified team member that she had previous knowledge of the MHSU and his family and believed there to have been a problem of domestic violence during this time. The record made of this exchange merely states 'violence and aggression' on the risk assessment form. The consequence of the inadequate documentation was that subsequent staff assumed, not unreasonably, that the 'violence and aggression' referred to the MHSU's previous custodial sentence some 17-20 years previously and the precipitating behaviour to this. Consequently no other member of the CRHT or PICU, or the MHSU's consultant psychiatrist, was aware that domestic violence could be a risk issue in March 2006.

The key question therefore is what difference would better documentation of the third party information have made?

[Please see section 5.2.2 p21and 5.2.3 p22 for a more detailed analysis of the treatment of third party information by the Rotherham and Doncaster Mental Health Service and the impact of this on the subsequent actions of staff left unaware of the potential risk of domestic violence.]

Care Planning and the Care Programme Approach: The Trust's internal investigation reports do touch on the lack of quality in the care planning for this MHSU. The reports also note that the computerised and standardised approach currently in use within the Trust may not be conducive to dynamic care planning, which has the individual needs of each individual service user as the central driver to care plan content.

Comment by Investigation Team
We reviewed the nursing documentation as part of our overall assessment of the clinical records. The day to day progress notes completed by staff on PICU and ward C1 provided a good narrative of the MHSU's progress on both wards. The only aspect of these records that we considered lacking was when the MHSU complained about harassment from a fellow Service User. There was no evidence in the nursing records that the MHSU's complaint was taken seriously. The impression given in the records is that his perceptions were deemed to be purely related to his paranoia at the time. There is nothing to suggest that the MHSU was reassured that the PICU staff would speak

with the other service user about the MHSU's complaint about him. Subsequent enquiry by the Investigation Team revealed that in the 24 hour report for PICU there is an entry to the effect that the service user about whom the MHSU had complained had been intimidating towards fellow patients in general that evening and night.

The Preprinted care plans in use were uninspiring and did not present an individual plan of care. This being said, where there are set activities expected of staff and that these would be the same for every in-patient, (for example for individuals admitted under the Mental Health Act), to have a pre-printed care plan seems to be logical. However, only to have pre-printed care plans is not conducive to individualised care.

With respect to the admissions paperwork, we can see the merits of having a designated check list approach to this. This provides an easy mechanism to double check that all issues that need to be undertaken with a newly admitted patient have been addressed in the designated time period.

CPA

The level of CPA that this MHSU was placed on was "Standard". This was appropriate. He was being followed up by his consultant psychiatrist only and did not at the time of discharge have a community worker.

His CPA care plan, however, was insufficient. The document is pre-prescribed and did not address any of his personal needs, for example:

- The exploration of his alcohol intake, the triggers for the increase in alcohol and exploring ways in which he could reduce this.
- The development of better coping skills for managing his stressors.
- The introduction of cognitive behavioural techniques.

There was no risk management plan and no relapse prevention plan documented at any point of the MHSU's admission to PICU or Ward C1. Neither plan is dependent upon a service user being placed on Enhanced CPA.

Clinical supervision: This was not examined within the internal investigation reports. Given the limited contact of the MHSU with the mental health service, and the lack of evidence that supervision factors were contributory to any weaknesses identified in the practice of staff, the Investigation Team is satisfied that not to have explored supervision issues was reasonable.

Interagency communication: This was not an issue in this case. However, it is clear from the internal reports and our discussions with staff that excepting the issue of domestic violence there appear to have been good interactions between members of the CRHT, PICU, Ward 1 and the CSS regarding this MHSU and his wife.

Housing: This was not an issue in this case.

Support for carers: As already highlighted, the provision of support to the wife of the MHSU represented good practice and is to be commended.

Team performance and leadership: There is no evidence that these issues were explored within the internal investigation report. Having reviewed the case management ourselves, and met with the staff involved with the MHSU, and their managers, the Investigation Team detected no concerns in relation to the management and leadership of the teams of staff involved.

Service culture: There is no evidence in the Trust's internal investigation reports to suggest that service culture was explored. Broadly speaking the Investigation Team has not detected any concerns regarding service culture. However there are two cultural issues that the Trust may wish to explore further within its adult services. These are:

- Staff attitudes to risk assessment, and risk assessment documentation.
- How staff manage accusations of bullying between service users.

As previously highlighted in this report there were issues of inadequate documentation in relation to the MHSU's risk assessment, both in relation to what was recorded and in relation to the lack of full risk assessment even though this was indicated. Because of the central importance of the risk assessment process to the delivery of safe and effective care, the Trust needs to test out how widespread these problems are.

There was also a lack of documentation about the actions staff took in response to the MHSU's allegation of bullying from a fellow patient. This may well have been a documentation oversight. Nevertheless the Trust should assure itself that staff do investigate and document the actions they have taken in all such instances.

Conclusion:
The overall conclusion of the Trust's own investigation was that "there had not been any significant failings in the service provided and that the fatal assault by *the MHSU* on his wife could not have been predicted."

The independent conclusion is presented in section 7 page 27 in this report

Recommendations made within the Trust reports

There are no recommendations made as such within the main body of the internal investigation report which is unusual. However there is a five point action plan attached to the Trust board's report. The key features of the action plan were to:

- Review the recording requirements expected of staff and use of the associated documentation tools.
- Discuss the care and management of the MHSU within medical education and peer review sessions.
- Consider exploring further the possible reaction of this MHSU to selective serotonin reuptake inhibitor (SSRI) medication and apparent impulsive acts.
- Provide feedback to the involved clinical teams about the internal investigation reports.
- (For action by the Strategic Health Authority) to commission an independent review.

It is the view of the Investigation Team that the above represents a rather lightweight action plan and does not provide confidence that the practice issues of most concern in this case will be addressed effectively. We would have liked to have seen much more specific information relating to the work that needed to be undertaken. For example:

- "The Director of Nursing will commission a full audit across all services of the quality of documentation of as well as the completeness of risk information. In particular such an audit will seek to determine;
    - The frequency with which identified risk behaviours are appropriately described within the current risk assessment documents. For example are the antecedents to the behaviours documented and the previously known consequences of these behaviours?
    - The frequency with which a full risk assessment has been undertaken where indicated on the initial brief assessment.
    - Whether risk assessments are dated and the author(s) of the document is /are clearly documented.
    - The frequency with which a risk management and risk relapse plan is created with service users, and the quality of documentation contained within these plans.
    - Whether service users only have 'pre-printed' care plans, or whether there is evidence of individualized care planning.
    - In inpatient admission paper work and the initial medical assessments, how often is information relating to pre-morbid personality recorded?"

5.2.2 How third party information is viewed and treated by staff

The underutilisation by staff of the third party information revealed about the MHSU in this case was potentially a significant influencing factor in the subsequent case management. In this case information shared by the sister of the deceased suggests that, even had staff been aware, it is unlikely that questioning of the MHSU or his wife would have resulted in validation of the information. This however is irrelevant to the principle of good and effective information sharing between team members and across team boundaries.

To obtain a better sense of staff perspectives on this matter six staff were asked to record their personal perspectives about how they view and would use third party information. Their comments were (some staff made more than one comment) that:

- Third party information is important and that they would document this, including the source of the data. (3 staff)
- Such information could reasonably be utilised in the risk assessment documentation. (2 staff)
- If clinically appropriate the information would be shared with colleagues as third party information can be highly relevant to clinical decision making. (1 staff)
- Where possible one would attempt to make further enquiries to clarify the details of the information. However it is recognised that this may be difficult. (4 staff)

One member of staff revealed that:

- "Historically third party information has been used by individual clinicians and only shared with the chosen few"
- It would not be usual for third party information to be recorded anywhere.

One staff member said:

- Using third party information is difficult if the informant only knows the service user informally.
- Informal information falls outside the standardised process of risk assessment.
- Under exceptional circumstances one should discuss such information in the multi disciplinary setting.

The overriding impression the Investigation Team has is that all believe third party information to be important. However ambiguity prevails over how one should treat that information in terms of:

- where it should be recorded;
- sharing it with colleagues; and
- whether one informs the service user.

5.2.3 What difference it would have made to staff actions and decisions had they been aware that there was domestic violence directed by the MHSU towards his wife.

Had the information relating to the reported previous domestic violence in the home of the MHSU and his wife been properly documented, the MHSU's nominated consultant psychiatrist told the Investigation Team he would have:

- spoken with the provider of the information to understand the reported concern better;
- attempted to have explored this with the MHSU; and
- arranged for the MHSU's wife to be interviewed specifically about this.

With regards to the CSS, they advised that had they been aware of any domestic violence in the MHSU's home then they:

- would have explored this with the MHSU's wife. This is something they do have experience with as a proportion of the carers they support have experienced some form of domestic violence and/or abuse.
- If the MHSU's wife opened up to them then they would have supported her in arranging an appointment with a local support agency called 'Choices and Options'. It is common practice for a member of the CSS to accompany a carer to their first appointment. They would have also ensured that the MHSU's consultant psychiatrist was aware.
- If the MHSU's wife had not revealed any information that confirmed that she had, or was, experiencing domestic violence or abuse, they would still provide her with information about local support groups and the police domestic violence unit so that she had the information if she ever wanted to use it.

With regards to the referral by the MHSU's consultant to the CRHT on 31 March, had information relating to domestic violence been communicated then the very nature of the referral, and the discussion between the accepting clinician and the consultant psychiatrist, may well have been different with consideration at the time of obtaining an ASW assessment instead, or agreeing next steps should the CRHT not be able to make contact with the MHSU or his wife.

Whether this further exploration with either the MHSU or his wife would have resulted in any different management of the MHSU, or whether the exploration would have revealed any meaningful information, is difficult to say. In this case it would seem unlikely that the MHSU's wife would have admitted to the violence she suffered. The reason this appears to be the case is that the victim's family had on a number of occasions urged her to seek help and during the period of his admission to the PICU tried to encourage her to leave with her children. Unfortunately she would not do this. Furthermore the sister of the

deceased told the Investigation Team that she was not at all confident that her sister would have revealed what was happening at home even under direct questioning.

Had an ASW assessment been activated it is impossible to say that this would have resulted in compulsory admission. It is just as likely that the MHSU and his wife would have presented themselves appropriately and that they were provided with the CRHT contact details. These the MHSU's wife had in any event.

5.2.4 The appropriateness of the MHSU's discharge home three days after his discharge from the Psychiatric Intensive Care Unit to an acute inpatient ward.

The Investigation Team is satisfied that the decision to discharge the MHSU from his detention under S2 of the MHA and to have discharged him home was appropriate and reasonable. The MHSU presented as fully recovered without the aid of any treatment and there were therefore no grounds to detain him further. He had been well for several days prior to his transfer to an open ward and his wife confirmed that he was 'back to his normal self' and was supportive of him coming home.

5.2.5 The decision of the Crisis Resolution and Home Treatment Team not to attend at the home of the MHSU and his wife – was it reasonable?

When the MHSU's consultant psychiatrist asked the CRHT to intervene following the concerns raised by the MHSU's wife on 31 March 2006, there was an assumption that the team would be able to effect a face-to-face assessment. Also at the time of this referral there were no concerns regarding any violence and aggression risk in relation to the MHSU and definitely no domestic violence concerns. Furthermore at the time of the referral neither the MHSU nor his wife was aware that CRHT support had been sought.

The service profile for the CRHT says it will:

- "For individuals with acute and severe mental health problems for whom home treatment would be appropriate, provide immediate multi-disciplinary, community based treatment 24 hours a day, 7 days a week."

It also says that the following are important:

- a 24 hour, 7 day a week service;
- rapid response following referral;
- intensive intervention and support in the early stages of the crisis;
- active involvement of the service user, family and carers;
- assertive approach to engagement;
- time-limited intervention that has sufficient flexibility to respond to differing service user needs; and

- learning from the crisis.

The document also says:
"The team will provide a rapid response. Where possible, assessment will commence within two hours from the referral being received and will involve:

- Initial screening to ensure the service is appropriate to the individual's needs. (Where not appropriate a referral will be made to an alternative service and/or the referrer advised accordingly)
- Undertaking a multi-disciplinary assessment of the service user's needs and level of risk. The assessment, will take account of physical, social, psychological, familial and cultural needs
- Actively involving the service user, carer(s), family and all relevant others in the assessment process
- Arrangements for a physical health assessment where appropriate
- On completion of the assessment, a focused care/risk management plan will be produced which outlines the level of input and number of visits required, building in sufficient flexibility to respond rapidly to changes in the clinical situation"

In this case two issues stand out. The need for the 'active involvement of the service user, family and carers' and the team's stated intention of trying to effect assessment within two hours of referral.

The need for active involvement of the service user, family and carers:
We know that the MHSU already had suspicions about the mental health service and was also suspicious of his wife's intentions regarding having him readmitted to hospital. The MHSU's wife had also expressly informed the CSS that she did not want her husband readmitted, she just wanted to be able to talk and to feel supported in managing a difficult situation at home. Although not an entirely unusual circumstance, the fact that neither the MHSU nor his wife were aware that the CRHT had been asked to intervene did therefore act as a barrier to the team in taking a more assertive approach in effecting contact with the family. The stated views of the MHSU's wife, and information relating to the MHSU's perceptions regarding his wife, also acted as a brake to more assertive action by the CRHT. The decision at the time was that a gentle approach would be in the best interests of the MHSU and his wife.

On the basis of the information the CRHT professionals had available to them on 31 March a cautious approach was not unreasonable.

The CRHT's stated intention to try and effect an assessment within two hours of receiving and accepting a referral.

In this case no face-to-face assessment was achieved. It is also accepted that the tenor of the discussion with the referring consultant would in all probability have been quite different if the third party concerns regarding domestic violence were known. However it does appear that there is a gap in the service profile for the CRHT. Nowhere does it address the foreseeable scenario where assessment cannot be achieved. There is no mandate setting out what the CRHT will do to ensure that the referrer is made aware that they have been unable to conduct the assessment within their usual timescales, or any defined timescale. Furthermore it does not appear to be part of the CRHT's process in the acceptance of a referral to agree next steps or a contingency plan should positive contact with a service user not be possible. This is something that the CRHT team may wish to consider when it updates its service profile.

6.0 OTHER ISSUES ARISING FROM THE INVESTIGATION

The other main issue arising from this investigation was staff concerns about the current approach to risk assessment in the Trust. Staff revealed:

- That the format of the risk assessment discourages clinicians from being thorough. The numbers of forms to be completed can be particularly burdensome.
- There is a lack of confidence about how much the information on the Trust's current risk documentation actually informs clinical care.

From our own observations the Investigation Team appreciates that a good risk assessment can only be completed over time, and will in many cases take some days if not weeks to complete, as the risks alter in line with the service user's changing mental health state. Nevertheless we did form the impression that the current documentation tools do need some development work.

The brief risk assessment tool does not seem to lend itself to good quality textual descriptors. Neither does it prompt consideration of safeguarding issues for children or adults.

The full risk assessment form does allow for good quality textual information, in particular the recording of the consequences of previous risky behaviour. However the length of the assessment form we appreciate could be off putting to the staff required to complete this.

Because of the central importance of the risk assessment process to delivering a safe mental health service, it would seem prudent for the Trust to find out from a broader range of staff what their views about the current paperwork is and what they feel could be done to make it

- more manageable; and
- more clinically useful.

7.0 CONCLUSION OF THE INVESTIGATION TEAM

As a result of this investigation the Investigation Team concludes that there was nothing the mental health services could have done to prevent the attack by the MHSU on this wife on 2 April 2006. It is also important to note that the family of the victim in no way holds any of the mental health services responsible for what happened. The sister of the deceased had been concerned for some time that a serious, if not fatal, injury would befall her sister as a result of the domestic violence she experienced.

However there are three important learning and reflection points for the service. These are:

- Where information is recorded on any CPA or risk assessment document it must be contextualised. Had the initial risk information relating to previously known domestic violence been clearly recorded, i.e. the meaning behind the words 'violence and aggression' stated plainly, then it would have provided impetus and opportunity for subsequent health and social care professionals to explore this with both the MHSU and his wife. Whether such explorations would have revealed information relating to domestic violence in this case is extremely unlikely.

- Where a professional indicates that a full risk assessment is required for a service user, the professional with immediate ongoing care responsibility for the service user should carry this out. In this case it would have been the MHSU's named nurse or other nominee on the PICU where the MHSU was resident for ten days, giving ample time to have conducted this.

- Although the MHSU's consultant psychiatrist and the CRHT were aware that the MHSU had taken his wife's mobile phone, no-one discussed what the contingency plan was if the CRHT could not make contact with the MHSU. It was almost as though there was a tacit assumption that the team would be able to effect a face-to-face assessment. Although this may not have been an unreasonable assumption in this case it has highlighted the subtle complexities and issues that such teams have to consider in coming to a decision to 'wait and see' or to attend at a service user's home unannounced. Where it is plainly evident, as it was in this case, that there may be challenges in effecting a successful contact, consideration of a contingency plan would be sensible. However, in this case even if a decision had been made to initiate an ASW assessment it is unlikely that it would have resulted in a full Mental Health Act assessment and the compulsory detention of the MHSU. In fact the family of the victim believes that both husband and wife would have presented a united front.

8.0 RECOMMENDATIONS

The Investigation Team believes that the care and management of the MHSU was appropriate and in this case we do not believe that anything done differently by the mental health teams would have averted the tragedy that occurred. However the analysis of the MHSU's care and treatment did highlight a number of issues that if left unaddressed may prevent the mental health service from averting serious incidents in the future.

These are:

For The Chair of the Trust Risk Management and Healthcare Governance Committee:

- How the Trust treats third party information, especially where it relates to the potential for risk behaviour in a service user, needs to be debated within the Trust's governance and risk management groups. It is not acceptable for staff to be expected to use their individual judgment on such an important and sensitive issue. Subsequent to this:
  - clear guidance on the use of third party information must be incorporated into the operational policies of all services within the Trust,
  - the issue of managing third party information needs to be incorporated into the Trust's CPA and risk assessment workshops,
  - consideration should be given to including the issue of the management of third party information in the local team based induction process for new staff members.

- Exploring safeguarding issues, both in relation to children and adults, can be challenging. The Trust needs to introduce a section on safeguarding children and adults, to include domestic violence (emotional, verbal and physical) as part of the standardised screening and full risk assessment paperwork.

- Although it is not uncommon for mental health service users to have a higher alcohol intake than is recommended, the Trust needs to develop a more proactive approach to the education of its service users about excessive drinking and also information about local support groups if the service user and/or family members and carers are concerned about the service user's alcohol intake. Standard information that could be provided to service users can be found at :

  http://www.alcoholicsanonymous.org.uk/newcomer/pack.shtml

  Information that could be provided to families and carers is at:

  http://www.al-anonuk.org.uk/alanon/index.asp

The Trust could also identify local AA meetings near to its inpatient units, make contact with the local AA group representatives and make an offer of the use of Trust premises for free for their meetings. This would make open AA meetings easily available to staff who want to understand alcoholism and alcohol abuse more, and also make attendance easier for inpatients who accept that their drink habits are damaging their lives.

- As part of the Trust's ongoing commitment to improving its approach to, and standard of client focused risk assessments, the Trust needs to commit to a regular audit of risk assessment documentation that assesses the quality and clinical usefulness of what has been documented. As highlighted on page 20 of this report examples of the types of issues this Investigation Team would expect to see addressed within such an audit are:
    - The frequency with which identified risk behaviours are appropriately described within the current risk assessment documents. For example are the antecedents to the behaviours documented and the previously known consequences of these behaviours?
    - The frequency with which a full risk assessment has been undertaken where indicated on the initial brief assessment.
    - Whether risk assessments are dated and the author(s) of the document is /are clearly documented.
    - The frequency with which a risk management and risk relapse prevention plan is created with service users, and the quality of documentation contained within these plans.
    - Whether staff only use 'pre-printed' care plans, or whether there is evidence of individualised care planning
    - In the inpatient admission paper work and the initial medical assessments, how often is information relating to pre-morbid personality recorded?

- As part of the Trust's ongoing commitment to improving its approach to, and standard of client focused risk assessments, the Trust should consider conducting a survey of all of its staff to find out:
    - what works well in the risk assessment process;
    - what elements the staff feel need to be improved and how this could be achieved; and
    - how valuable the staff find the clinically focused risk assessment currently provided, and where it is and is not meeting their needs.

- The Trust must produce a detailed project plan with realistic timescales attached to it for the SHA and PCT in relation to its intended developments in relation to its intention to
    - undertake a contemporary review of its risk assessment and CPA paperwork to assess its compliance with current national standards and best practice guidance;
    - implement a common risk assessment process across all of its services; and
    - explore options for more responsive approaches to assessment based on need (including safety), integrated working, communication, effective record keeping and the effective supervision of staff undertaking these assessments.

Working Age Adult Services

- **Crisis and Home Treatment**
    - The service manager for the CRHT recognises that their current service profile document is out of step with the way the CRHT currently operates. He has made a commitment to updating this service profile, incorporating the feedback contained in this report by the end of November 2008.

- **Management Team and Governance Committee for Adult Services**
    - The thorny issue of how to manage inter-team referrals where the service user is unaware of the referral needs to be properly debated within the context of good governance. It does not seem to be sufficient that the CRHT simply refuse to accept such referrals. **Note** The assistant directors of in-patient and community services must ensure that this issue is properly addressed through the adult services governance arrangements and ensure that all in-patient ward managers and CMHT leaders and consultant psychiatrists are aware of the outcome of how referrals to teams such as the CRHT are to be managed where the service user and/or family are unaware that a referral has been made.

Note:
Each of the above recommendations needs to be properly considered in the context of other existing and planned developments for the Trust and in particular adult services. It is the Investigation Team's anticipation that the recommendations made may be able to be incorporated into developments the Trust is already considering in relation to risk assessment and documentation in general.

APPENDIX 1 – CHRONOLOGY OF THE MHSU's CONTACTS WITH MENTAL HEALTH SERVICES

This chronology gives a comprehensive picture of the MHSU's contacts with Mental Health Services between 9 March 2009 and 2 April 2006.

Date	Contact
9 March 2006	The first contact with mental health services occurred during the day. The Crisis Team 'day and night report' says: MHSU "referred by GP. Arrived in A&E. Very paranoid, fixed beliefs that the local neighbourhood think he is a paedophile, thinks his wife is part of the conspiracy to get rid of him, has been drink driving to escape perceived people after him, handed himself into police x2. Agreed informal admission on C1, escorted to ward. The MHSU stayed 10 minutes and then left before a section 5.2 could be applied. He could not be persuaded to stay. ASW contacted at 12.15pm to request an assessment under the Mental Health Act. GP surgery was closed therefore communication with GP not possible. The MHSU's nominated consultant psychiatrist notified." The screening assessment tool completed by the crisis and home treatment social worker (SW1) notes that the MHSU is "untrusting and suspicious, no insight, does not think he needs treatment." The assessment also notes that he has been prescribed Prozac by his GP but has only taken it for two days.

Date	Contact
9 March 2006 12.30pm	The Mental Health Act assessment completed by the two Approved Social Workers (ASW's) confirms the initial information gathered by the initial assessment in A&E. The MHSU's wife is present throughout the assessment. The MHSU reveals no information relating to illicit drug use. His wife also reports no illicit drug use. She does however report an alcohol intake of 4-5 cans of Stella a night. As there were two ASW's present one of them (ASW2) took the MHSU's wife into the kitchen and spent time with her as she appeared to be upset which she was. During this private meeting she said nothing that revealed any level of domestic violence in the home. The impression at the time is that the MHSU is suffering from a delusional disorder. With regards to his risk factors he is noted to display a risk of harm to self and a risk of harm to others. The risk of harm to others was considered in relation to his impulsive and reckless behaviour when he left the home after an argument with his wife, driving to Cambridge under the influence of alcohol. A decision was made to section the MHSU under Section 2 of the Mental Health Act in view of his ambivalence in response to offers of community support available, including community support at home. Furthermore the MHSU would not consider an informal admission.

Date	Contact
9 March 2006 – 10.30pm	The MHSU is admitted to the Psychiatric Intensive Care Unit under Section 2 of the Mental Health Act. . His consultant psychiatrist is informed. The admission states that the reason for admission is : “assessment and treatment. He believes that people think he is a paedophile which has resulted in him thinking that the police are chasing him”. The medical assessment provides good information about the MHSU’s personal history. It is noted that he has been married for 17 years and that he has seven and five year old children and that he is happy with his family. In terms of social stressors the assessment document notes that the MHSU declared himself bankrupt in November 2005. It is noted that the MHSU found this situation unpleasant but a relief. The MHSU’s alcohol intake is stated as +/- 20 pints a week and that he drinks four times a week. His only forensic history is noted as a three year custodial sentence at the age of 17 years for grievous bodily harm having been involved in a group fight. No informant history is recorded. Outcome of the assessment: The assessing Foundation SHO notes that “life stressors have triggered the MHSU’s delusional ideas and illness”. The differential diagnosis is noted as: ❑ Depressive episode ❑ Delusional disorder There are no thoughts of self harm or harm to others at the time of this assessment. The assessing SHO considers the MHSU’s risk of harm to others to be very low. Medication is noted to be Prozac which was commenced two weeks previously by his GP. The assessment was completed at 11.35pm

Date	Contact
10 March 2006	The MHSU is assessed by a locum SHO at the request of the staff on PICU. He is noted to continue with his paranoid thoughts and his depression is noted to be mild to moderate. He is not considered to be psychotic. It is also noted that the MHSU is not anxious about going on to the ward and mixing with other people. The plan at this stage is to continue with Prozac 20mg once a day. To continue to monitor and to discuss the MHSU's care and management with the PICU consultant.
13 March 2006	There is a consultant led ward round. It is noted that the MHSU continues to feel up and down on the ward. It is also noted that he feels that the tablets are taking effect and overall he is feeling better. He is noted to be eating and sleeping well. It is noted that he has insight and is accepting help and medication. The plan is to stop the Prozac, to commence amisulpride 200mg twice a day. (Amisulpride is an anti-psychotic medication and was considered more appropriate for the MHSU). The MHSU is also to commence 'fresh air leaves'.

Date	Contact
16 March 2006	It is noted in the medical records that the MHSU has developed stiffness. Five mg of procycladine administered. The MHSU is noted to be refusing to continue on amisulpride. It is also noted that the MHSU developed a panic attack for around 10 minutes and that he had difficulty in breathing and was fainting. His blood pressure was noted to be 150/11 with a pulse of 80 beats per minute (bpm). On examination he was not stiff, he had no pallor and no cyanosis. He was therefore reassured and given lorazepam and oxygen via a face mask. The MHSU is noted to have calmed down and then to have gone to sleep. The plan was to: ❑ Stop the amisulpiride ❑ Commence lorazepam on as an required basis (prn) ❑ Conduct physical observations every 15 minutes
20 March 2006	There was a consultant led ward round which was attended by the MHSU's wife. In a meeting before this with the MHSU's wife staff reported that the MHSU was settled, was not delusional, continued in low mood and was missing his family. The MHSU was 'seen'. It was noted that he had been off all medication since the previous Thursday, that he was feeling better now and wanting to go home. His wife is noted to describe him as 'back to his normal self'. It is again noted that he is not delusional, there are no psychotic symptoms and that his speech was normal. The plan was to transfer the MHSU to ward C1 the same day.
20 March 2006 12.55pm	The MHSU is assessed by a level 2 Foundation SHO on admission to C1. His history is noted as previously. The only slight difference is that the MHSU is noted to regret his action drink driving and of turning himself in to the police as he has now lost his driving licence as a result. The records note that the MHSU now 'feels back to normal'. His wife was also present and it is noted that she agreed with this.

Date	Contact
20 March 12.55pm assessment cont..	It is noted that the MHSU feels angry as he believes he was told that he could have leave for a day from C1. The MHSU was advised that it was not possible yet. The MHSU is noted to have calmed down by himself. His speech is noted to be normal in rate and rhythm and appropriate in content. In terms of his thoughts he is noted as saying:I know the accusations weren't true" He also denied any thoughts of self harm. The MHSU is noted to have no visual or auditory hallucinations. The plan: ❑ No changes to his medication ❑ For escorted leave with staff in the grounds. If no difficulties then he can go on ground leave with his wife on 21 March.
21 March 2006	Consultant led ward round: It is noted that the MHSU is displaying no signs of mental illness that he has been cooperative on the ward and is sleeping well. The result of the ward round and discussion with the consultant psychiatrist was that the consultant did not believe that there was any further need for the MHSU to be in hospital. He was therefore to be discharged home with outpatient follow up with the consultant. The MHSU section was lifted the same day.

Date	Contact
29 March 2006	The MHSU was seen in outpatients by his consultant psychiatrist. He was accompanied by his wife. In his letter to the MHSU's GP the consultant psychiatrist has written: "There is no evidence to suggest any delusional thinking, although he still remains somewhat highly strung and anxious. There are no major depressive symptoms." It is also noted that the MHSU's anxiety state is "causing a significant amount of friction between himself and his wife and I have encourage him to seek out some physical activities, which would allow the two of them some breathing space." Because of the MHSU's anxiety state the consultant suggested Cipramil 20mg once a day which the MHSU was "amenable to consider". A further supply of Zopiclone 3.75mg nocte was also provided to cover a two – three week period. The Consultant psychiatrist notes in bold that he "would not wish this to become an ongoing prescription". It is also noted that the consultant will refer the MHSU for community support. His next appointment is scheduled for two months time.
31 March 2006	The Carer Support Service received a telephone call from the MHSU's wife. The records note that she was quite distressed. It is also noted that: ❑ She feels her husband remains quite paranoid ❑ The MHSU has taken his wife's phone off her ❑ The MHSU has taken the disability living allowance forms from his wife as he believes they are to send him back into hospital ❑ The MHSU's wife reports that her husband is accusing her of trying to give him an overdose. ❑ The MHSU's wife feels unable to cope without support. The CSS agreed to contact the MHSU's consultant's secretary to check on his discharge details. The records show that: ❑ CSS make contact with C3 and then C1 ❑ CSS do make contact with the secretary for the MHSU's consultant psychiatrist, and the concerns of the MHSU's wife are communicated to her for onward communication to the Consultant Psychiatrist.

Date	Contact
31 March cont..	A further call is received by CSS from the MHSU's wife. The record made says: "She reports she doesn't want her husband in hospital. Just felt alone and wished to speak to someone about how to handle the situation." She also reports that she knows of the referral at Cornerstones Community Mental Health Team for a community psychiatric nurse to be assigned to her husband. . She is also advised of a venue where she can attend for herself if she wants to talk but not at home. She advises CSS that she will contact them when (if) she requires this. She also advised CSS that she had the crisis and home treatment number if she needed help or advice over the weekend.
31 March 2.20pm	The CSS records show that they did advise the Crisis Team of the concerns of the MHSU's wife.
31 March 2006 3.05pm	The CSS receive a telephone call from the Crisis Team. The records show that the CSS are informed that the Crisis Team have been asked by the MHSU's consultant psychiatrist to intervene in the situation at the MHSU's home. Case material is faxed to the crisis team. It is also noted that the CSS are aware that the MHSU has taken his wife's mobile so contact with her may be difficult.
31 March – 1 April	The Crisis Team make a number of attempts to contact the MHSU and his wife by phone. These attempts are unsuccessful.
1 April	The MHSU and his wife visit his mother in-law.
2 April am	The incident occurs.

APPENDIX 2 - Sources of Information Used to Inform the Investigation's Findings

Persons Interviewed:
The interviews with staff constituted a mix of 1:1 interviews, telephone interviews and a round-the-table meeting.

- Specialist Registrar – Adult Services and medical assessor during Mental Health Act Assessment on 9 March 2006
- Social Worker, Care & Support Unit
- The MHSU's Consultant Psychiatrist
- Staff 1 - Crisis Resolution and Home Treatment Team
- Staff 2 – Crisis Resolution and Home Treatment Team
- Staff 3 – Crisis Resolution and Home Treatment Team
- Team Leader - Crisis Resolution and Home Treatment Team
- C3 (PICU) Ward Nurse
- Service Manager – Crisis Resolution and Home Treatment Team
- ASW 1
- ASW 2
- Consultant Psychiatrist PICU

Telephone Discussion and written correspondence
With the sister of the deceased.

Face to Face meeting
With the mother and sister of the deceased.

Documents Reviewed
All of the MHSU's mental health records
The Trust internal investigation reports x3.
Best Practice in Managing Risk July 2007 Department of Health
Crisis and Home Treatment Service Profile 2004

GLOSSARY

Care Programme Approach

The Care Programme Approach has four main elements as defined in 'Building Bridges: A guide to arrangements for inter–agency working for the care and protection of severely mentally ill people'. DH (1995) London HMSO.

These are:

- Assessment: Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;
- A care plan: The formation of a care plan which addresses the identified health and social care needs;
- A key worker: The appointment of a key worker (now care co–ordinator) to keep in close touch with the patient and monitor care; and
- Regular review: Regular review, and if need be, agreed changes to the care plan.

The cornerstones of the CPA

These four principles, of assessment, care plan, care co–ordination and review are the cornerstones of the Care Programme Approach. Implicit in all of them is involvement of the person using the service, and where appropriate, their carer.

Modernising the CPA

In 1999, the Government undertook a review of the CPA which was considered timely for a number of reasons including:

- the introduction of the National Service Framework for Mental Health, published in September 1999;
- the lessons learnt through research, reviews and inspections; and
- the need to listen to professionals' views about the CPA. The review resulted in the publication of 'Effective Care Coordination in Mental Health Services, Modernising the CPA', published in October 1999.

Key changes

This confirmed the Government's commitment to the CPA for working age adults in contact with secondary mental health services and introduced changes to the CPA. The key changes are:

- Integration of the CPA and care management — the CPA is care management for people of working age in contact with specialist mental health services.
- Appointment of a lead officer — Each health and social services provider is required to jointly identify a lead officer to work across both agencies.

- Levels of the CPA — two levels of the CPA must be introduced — Standard and Enhanced.
- Abolition of the supervision register — from April 2001, supervision registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place.
- Change of name — key worker to be referred to as care co–ordinator.
- Reviews of care plans — the requirement to review care plans six-monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set.
- Audit — regular audit is required looking at qualitative implementation of the CPA.
- Risk assessment/risk management — risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to have a crisis plan and contingency plan.

Standard CPA
Standard CPA is for people who require the support of only one agency. People on standard level will pose no danger to themselves or to others and will not be at high risk if they lose contact with services. The input of the full multidisciplinary community health team will not be required – service users on standard CPA will generally require the support of one or two members of the team.

Enhanced CPA
Enhanced CPA is for people with complex mental health needs who need the input of both health and social services. People on enhanced CPA generally need a range of community care services. This group of people may include those who have more than one clinical condition and also those who are hard to link with services and/or with whom it is difficult to maintain contact. Some people on enhanced CPA are thought to pose a risk if they lose contact with the services. Generally speaking, enhanced CPA tends to apply to people with more severe mental health problems such as schizophrenia or manic depression. In some cases, enhanced CPA can gain you better access to services.